S. HRG. 108–489

SUICIDE PREVENTION AND YOUTH: SAVING LIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINING CERTAIN MEASURES TO HELP PREVENT SUICIDE AMONG CHILDREN AND ADOLESCENTS

MARCH 2, 2004

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C O N T E N T S

STATEMENTS

MARCH 2, 2004

ADDITIONAL MATERIAL

SUICIDE PREVENTION AND YOUTH: SAVING LIVES

TUESDAY, MARCH 2, 2004

U.S. SENATE,
SUBCOMMITTEE ON SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES,
OF THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:08 a.m., in room SD–430, Dirksen Senate Office Building, Senator DeWine, (chairman of the committee) presiding.

Present: Senators DeWine, Kennedy, Dodd, Harkin, and Clinton.

Senator DEWINE. Good morning. We welcome all of you this morning.

Senator Kennedy will be here in just a moment. I think we had better get started as we have a series of votes that begin at 11:30 and there are many votes, which means that we will not be able to get back here at all after 11:30. So this hearing will end at 11:30.

We have a number of very important witnesses. So I think we will go ahead and get started and I will make an opening statement.

OPENING STATEMENT OF SENATOR DEWINE

Senator DEWINE. We are meeting today to discuss the problem of youth suicide and how we can help to prevent it. Statistics tell us that approximately every 2 hours a person under the age of 25 commits suicide. We also know that from 1952 to 1995 the rate of suicide among children and young adults has tripled, and that between 1980 and 1997 alone the rate of suicide in 15- to 19-year-olds increased by 11 percent.

According to the National Institute of Mental Health suicide was the 11th leading cause over all for death in the United States in 2001. However, it was the third leading cause for youths ages 15 to 24. Shockingly, we also know that suicides outnumber homicides three to two.

We also know that boys are killing themselves at a ratio of five to one to girls in the 15-to-19-year-old age group and at the ratio of seven to one in the 20- to 24-year-old age group. However, while boys are dying at higher rates, girls in these age groups are attempting at a much higher rate. It has been estimated that there may be from 8 to 25 attempts made for every suicide death.

These alarming numbers emphasize the need for early intervention and prevention efforts. Too often the signs may be subtle or hidden until it is too late. While research has created improved medications and methods for helping those with mental health problems to recover, there is still much work to be done in identifying those who need help.

A great deal of study has been done on the risk factors related to suicide. In children and youth these are known to include depression, alcohol or other drug use, physical or sexual abuse, and disruptive behavior. Of people who die from and who attempt suicide, many suffer from co-occurring mental health and substance abuse disorders.

We also know that attempts at suicide are not just harmless bids for attention. These attempts indicate a serious problem. Like anyone else with a life threatening condition, those suffering from a desire to do themselves harm should not be left alone and should receive immediate medical care and attention.

As a result of the need for increased attention to the problem of suicide and the need to provide access to help, I am currently working with Senator Dodd on a bill to provide support for state-wide plans to intervene and prevent the occurrence of suicide in youth. We commend the States which have already created such plans and hope to encourage all States to take this important step.

I look forward to the recommendations that we will hear today from experts on the mental health of young people with regard to this bill and for those who work with children and youth and from those who lost loved ones.

I know that through the stories of their tremendous loss and heartache, they can help us to understand the scope of this problem and what needs to be done.

[The prepared statement of Senator DeWine follows:]

PREPARED STATEMENT OF SENATOR DEWINE

Thank you all for being here today. I'd like to welcome Ranking Member Kennedy, with whom I have worked on many issues concerning children over the years.

Today, we are meeting to discuss the problem of youth suicide—how we can help to prevent it. Statistics tell us that approximately every 2 hours, a person under the age of 25 commits suicide. We also know that from 1952 to 1995, the rate of suicide in children and young adults has tripled and that between 1980 and 1997, alone, the rate of suicide in 15 to 19 year-olds increased by 11 percent. According to the National Institute of Mental Health, suicide was the 11th leading cause overall for death in the United States in 2001. However, it was the 3rd leading cause for youth ages 15 to 24.

Shockingly, we also know that suicides outnumber homicides 3 to 2.

We also know that boys are killing themselves at a ratio of 5 to 1 to girls in the 15- to 19-year-old age group and at a ratio of 7 to 1 in 20 to 24-year-olds. However, while boys are dying at a higher rate, girls in these age groups are attempting at a much higher rate. It has been estimated that there may be from 8 to 25 attempts made for every suicide death.

These alarming numbers emphasize the need for early intervention and prevention efforts. Too often, the signs may be subtle or hidden until it is too late. While research has created improved medications and methods for helping those with mental health problems to recover, there is still much work to be done in the identifying of those who need help.

A great deal of study has been done on the risk factors related to suicide. In children and youth, these are known to include depression, alcohol or other drug use, physical or sexual abuse, and disruptive behavior. Of people who die from and who attempt suicide, many suffer from co-occurring mental health and substance abuse disorders.

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INTRODUCTIONS

First, I would like to welcome my colleague from Oregon, Senator Gordon Smith, and his wife Sharon, who tragically lost their son, Garrett, in September to suicide. I thank you both for coming here today and for your willingness to share your experience with us.

Second, I would like to introduce Dr. Cheryl Ann King. Dr. King is a licensed clinical psychologist and Associate Professor of Psychology at the University of Michigan. She also serves as director of the Child and Adolescent Program at the University's Depression Center and as Chief Psychologist in the Department of Psychiatry at the University of Michigan Medical School. For the past 15 years, Dr. King has focused on the problem of youth suicide and has devoted the majority of her clinical research to this devastating problem.

Third, I would like to introduce Ms. Joelle [joe-ell] Reizes [rise-es]. Ms. Reizes is the Director of External Relations for Screening for Mental Health. She was instrumental in transforming this nonprofit organization into one of the leading mental health screening organizations. Screening for Mental Health was responsible for creating the first-ever National Alcohol Screening Day and has also developed the SOS High School Suicide Prevention Program.

Mrs. Reizes has overseen the production and development of the Screening for Mental Health's educational videos, including "SOS: Suicide Prevention Training," and has authored educational bro-

chures, some of which have been distributed to more than 7,000 sites nationwide.

Fourth, I would like to introduce Laurie Flynn. Mrs. Flynn is the director of The Carmel Hill Center for Early Diagnosis and Treatment in the Division of Child and Adolescent Psychiatry at Columbia University. She is also currently serving as the national director of Positive Action for Teen Health. Before joining Columbia University in 2001, Mrs. Flynn served as the executive director of the National Alliance for the Mentally Ill for 16 years. She is a member of many national advisory boards and professional association committees, including the Clinical Trial Advisory Group and the Research Center on Managed Care for Psychiatric Disorders. Mrs. Flynn is the author of several articles and books on health services for the mentally ill and family support and was presented with the CNS award for Outstanding Service to Humanity in 2000.

Finally, I would like to introduce Fran Gatlin. Ms. Gatlin is currently in her 29th year as a practicing school psychologist and her 27th year in the Fairfax County, Virginia, public schools. She has been named Psychologist of the Year in a school system with more than 168,000 students. She has a Master of Arts degree in Educational Psychology. Ms. Gatlin is a member of the National Association of School Psychologists and the American Association of Suicidology. Ms. Gatlin has provided invaluable leadership in implementing school-based suicide prevention programs and is currently serving on a task force with the Fairfax Partnership for Youth to increase youth suicide prevention efforts across Fairfax County.

Senator DEWINE. Before I introduce the panel members, I would recognize Senator Dodd, if he has any comments.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. Thank you very much, Mr. Chairman. And Sharon and Gordon, thank you very much for being here. It means a great deal to have both of you here. I cannot tell you how saddened we all were to hear what you have been through, and your willingness to be here with us this morning says volumes about both of you.

And thank you, Mr. Chairman, for being involved in this as well. This is a very important hearing. This is the kind of hearing you wish you never had to hold. We have hearings, from time to time we like to talk about things that we think will make a difference. We think we can here. But this is the type of a hearing I wish we just never had to convene.

So I want to thank the chairman for calling it. It is a very important issue obviously, for all of us.

I want to thank Senator Kennedy as well, and other members of the committee who have expressed strong interest in this subject matter.

And of course, I would like to welcome all of our witnesses who are with us and who will be speaking a little later this morning, and in particular Sharon and Gordon. Again, thank you both for being with us.

The loss on Garrett is something that all of us have felt as a result of our friendship with you. We want you to know that not a

day goes by we do not think about you, and pray for both of you. And so thank you again for joining us here this morning.

In September of the year 2001 I chaired the first Senate hearing on youth suicide in the Children and Families Subcommittee of this full Committee. And I want to begin this morning as I did then. I wish this year were not necessary. Yet we all know that it is.

Youth suicide is both a public and mental health tragedy, a tragedy that knows no geographic, racial, ethnic, cultural, or socioeconomic boundaries.

According to the Centers for Disease Control and Prevention over 3,000 young people take their lives each year, making suicide the third overall cause of death between the ages of 10 and 24.

Young people under the age of 25 accounted for 15 percent of all suicides in the year 2000. More children and young adults died from their own hand than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined.

Equally alarming are the numbers of young people who consider taking or attempt to take their lives. Recent CDC figures estimate that almost 3 million high school students, or 20 percent of young adults between the ages of 15 and 19 consider suicide each year. And over 2 million children and young adults actually attempt to take their own lives. I find these figures to be staggering and simply unacceptable.

And sadly, we rarely find these facts disseminated widely among the public audiences. We rarely read about them in newspapers or hear them on television. We know that youth suicide is intricately linked to mental health issues like depression and substance abuse. Yet we also know all too well that both youth suicide and children's mental health continue to carry an unfortunate stigma, a stigma that all too often keeps these crucial issues unspoken and discourages children and young adults from seeking the help that they so desperately need.

We have a societal obligation, in my view, to break through this stigma of youth suicide, to understand its causes, to reach out to our young people in this country so that they understand that whatever difficulties or illnesses they might be experiencing, they are not beyond help at all. We also have a societal obligation, in my view, to instill in our young people a sense of value, of self-worth and resilience so that they recognize their full potential in life and the love that their families, friends and communities have for them every single day.

I am pleased that our Nation has taken several positive steps toward better understanding the tragedy of youth suicide and its emotional and behavioral risk factors. The Federal Government, States and hundreds of community-based programs across this Nation are raising awareness by providing coordinated early intervention and prevention services to thousands of children and young adults, services that include comprehensive screening, assessment, individualized counseling and information resources.

Yet despite these important gains we still face some very, very significant challenges. Today, a very large number of States and localities are finding themselves with unprecedented budget deficits, making the establishment of new services and the retention of existing services increasingly more difficult. State-wide strategies to

coordinate services are often underfunded or understaffed to be properly effective.

In addition, significant questions had been raised about the use of antidepressants in children. It is critical and crucial, in my view, that we take steps to understand the effects of these drugs so that our children receive the best possible care.

Chairman DeWine and I plan to introduce bipartisan legislation that will further support the good work being done on the community level, the State level and the Federal level with regard to youth suicide. This initiative will support the further development and expansion of state-wide youth suicide early intervention and prevention strategies and the community-based services they seek to coordinate. It will encourage greater Federal support in the planning, implementation and evaluation of these strategies and services, and it will create a new interagency collaboration that will focus on research, policy development and dissemination of data specifically pertaining to youth suicide.

Finding concrete, comprehensive and effective remedies to the epidemic of youth suicide cannot be done by lawmakers alone on Capitol Hill. Those remedies must come from individuals, doctors, psychiatrists, psychologists, counselors, nurses, teachers, advocates, survivors and affected families who are dedicated to this issue or spend each day with children or young adults that suffer from illnesses related to suicide.

Therefore, Mr. Chairman, I look very much forward to hearing from our witnesses today, particularly Gordon and Sharon. I also look forward to working with all of you so that collectively all of us here together today and others, thousands and thousands across this country who want to be involved in this effort, that we can better understand this tragedy and that we can better develop effective public and mental health policies and initiatives that will reach every child and young adult in this country. Compassionate initiatives that give them encouragement, hope and above all life.

I thank you, Mr. Chairman.

Senator DEWINE. Thank you very much. Senator Harkin?

OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. Thank you very much, Mr. Chairman.

I just ask that my statement be made part of the record.

And again, I just really wanted to be here to show support to our friend and our colleague, Senator Smith and Mrs. Smith. What happened to you and Garrett and your family is just something that any parent just—I just do not know how you hold up under that kind of tragedy.

So I am here just as a friend and a colleague and just as a fellow parent, just to say that your faith and your strength and your willingness to be here to openly talk about your own tragedy gives us the courage, I believe, and the motivation to persevere and to come to some consensus on how we start addressing this issue that kind of has been swept under the rug for far too long in our society.

I just want you to know that you give us the courage and the motivation to persevere.

Thank you, Mr. Chairman.

[The prepared statment of Senator Harkin was not available at print time.]

Senator DEWINE. Thank you very much.

Senator Clinton?

OPENING STATEMENT OF SENATOR CLINTON

Senator CLINTON. Thank you very much, Mr. Chairman. And I thank both Gordon and Sharon. Thank you very much for being here. And I look forward to working with the chairman and with Senator Dodd.

And I hope, too, that we can put this into the larger context of how difficult it is for families to find the help that they need when their child exhibits either behavior or feelings or even attempts suicide. It still is very rare that a family can get access to the kind of mental health services that are sometimes quite helpful, and not always successful, but at least for some provide a real safety net.

So I thank you for holding this hearing, Mr. Chairman, and I particularly thank the Smiths for being here.

I would just ask that my full statement be included in the record.

[The prepared statment of Senator Clinton was not available at print time.]

Senator DEWINE. It will be made part of the record.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Thank you all for being here today for this hearing on one of the most tragic and personal issues affecting children and families across our Nation today—youth suicide. I especially want to thank Senator and Mrs. Gordon Smith and all the families here today for their courage in helping us understand this rising problem, that for so long has been misunderstood. Your testimony here today opens the door to a deeper understanding of mental illness and the steps we must take as a Nation to help troubled young people.

We all understand that no words can heal the deep pain or replace the great loss of an anguished child we love. But we can act to change the broken system of mental health services in our Nation. And we can strive to better understand the despair that leads young people to take their own lives.

The death of a young person has a devastating and long-lasting effect on family, friends, and the whole community, but it also says a lot about the society we live in. As Senator DeWine has pointed out, suicide is the third leading cause of death among adolescents—yet the years of lost potential and productive living are never really captured in those statistics.

We need to pay attention to the wake-up call these young people are giving so that another life is not lost due to mental illness. Access to mental health services is one of the most important civil rights issues facing our Nation today.

Our mental health system is fragmented, in crisis, and inadequate. Too many people are falling through the gaps and not getting the care they need, particularly children. One of the saddest symptoms of the crisis is more and more families are compelled to give up custody of their children because they cannot find and af-

ford the mental health services and supports they need. This is a disgrace to this Nation.

Last year, when President Bush announced the formation of the New Freedom Commission on Mental Health, he urged Congress to enact legislation that would provide full parity in the health insurance coverage of mental and physical illnesses. We must move forward on those proposals, because every day of delay represents lost lives.

It has been 3 years since "The Mental Health Equitable Treatment Act" was first introduced, and in this Congress it has broad bipartisan support. America's families should not have to wait any longer for this help.

But we must do more than assure adequate private insurance coverage for mental health. We must address structural weaknesses in our health care system which denies adequate care.

We must stem the flight of mental health practitioners from managed care networks. We must provide access to mental health services in schools.

We must fund training programs and provide incentives to address the shortage of mental health professionals who are trained to work with children and adolescents, particularly those who live in rural areas. And disparities in mental health services need to be eliminated.

The failure of one young person to obtain and continue with treatment can mean years of shattered dreams and unfulfilled potential. Children and young people with mental illness deserve health and happiness too—just as do those with physical illness.

In my State of Massachusetts alone, 13 percent of children face emotional challenges and are in need of mental health services. Nationally, one in five Americans will suffer some form of mental illness this year—but only one-third of them will receive treatment. Our Nation's families should not be left alone to endure the isolation, pain and sadness of seeing their child battle illnesses that seize the mind and break the spirit.

I commend Senator DeWine and Senator Dodd for their leadership and initiative in proposing grants to aid States with youth suicide prevention programs, particularly at a time when cash-strapped States are cutting funds for many vital services.

Now is the time for Congress and the Administration to take action to address the youth mental health crisis in our Nation, and I look forward to the important testimony we will hear today to help us frame the action we should take.

Senator DEWINE. We now welcome our colleague from Oregon, Senator Gordon Smith and Sharon Smith, who tragically lost their son Garrett in September. Gordon and Sharon, we thank you both for being here with us. We welcome your statement.

STATEMENT OF HON. GORDON SMITH, A U.S. SENATOR FROM THE STATE OF OREGON AND SHARON SMITH, SPOUSE

Senator SMITH. Thank you, Chairman DeWine, Senator Dodd, Senator Harkin, Senator Clinton.

Thank you for holding this hearing. As much as you wish you did not have to hold this hearing, we wish we were not your witnesses, but we need to be.

I also want to thank my wife Sharon, my colleague Ron Wyden, members of my staff who are here to help me get through this emotionally, to provide that kind of support.

September 8th, 2003 is a date that will forever tug at the heart strings of the Smith family. I was retiring for the evening when I heard a knock at the front door and moments later my wife, Sharon, was frantically calling me to come downstairs. Policemen were at the door.

These fine Montgomery County officers dutifully asked if they could sit down with us to share some difficult news. Respectfully, they told us that our son, Garrett Lee Smith, had been found dead in his college apartment—forgive me—the apparent victim of his own hand.

As his parents, we know how long and how desperately Garrett had suffered from his bipolar condition and his dark depressions. And while we knew intuitively that suicide was possible in Garrett's case, there are no adequate parental preparations, no owner's manual, to help one in burying a child, especially when the cause is suicide.

For me, in that moment, time stopped, joy evaporated, my public life seemed vain, and my hopes and dreams appeared as ashes. I felt I had failed at my most important responsibility in life—that as a father.

Now nearly 6 months later, a lot grayer and hopefully wiser, I can report to you, my Senate colleagues, what I have learned and what I hope to do in the wake of Garrett's death. I have learned that time goes on and that there is an end to tears. I have discovered that the best antidote to grief is gratitude, gratitude that the good Lord gave us Garrett for 22 years less a day.

I have determined that the best way to add meaning to Garrett's life and to find new meaning for my own is to discover ways and means to succor those who suffer like Garrett.

Sharon and I unwittingly began to do this as we wrestled with how, as public people, to share the news of our private loss. We decided simply to tell the tragic truth about our boy, that after years of psychological suffering and deep depression Garrett took his life to end his emotional pain.

Despite the lingering stigma of suicide, we decided just to announce it that way. The wisdom of this approach was confirmed to us weeks later by a sympathetic comment made to me by the dean of students at the University of Oregon. She consolingly said "Senator, thank you for telling the truth about your son's suicide. The next day our student health center was flooded by students seeking help, fearing that they were suffering Garrett Smith's problem."

Next in the midst of our mourning, we were sustained and nurtured by the help and prayers of family and friends and thousands, even ten thousand, well-wishers. People wanted to help. They wanted to do something proactive if possible to intervene in the lives of young people who may be dealing with depression and considering suicide.

So with the generosity of thousands, and under the auspices of St. Anthony's Hospital, the home town hospital in which I was born, at Pendleton, Oregon, we established the Garrett Lee Smith Memorial Fund. These resources will be utilized to purchase the

computers necessary to annually screen, with parental permission, all of the sixth grade children in Pendleton, Oregon using the Columbia TeenScreen program to identify children who are at risk for depression, suicide, or other schooling difficulties.

Also, St. Anthony's will establish a library resource center with books and software on mental health and a website for those with mental health challenges.

Here in the Senate I am working on two pieces of legislation which I commend to you, and that is not hard because you are the coauthors of them. The first is the Youth Suicide Early Intervention and Prevention Act. Senators Dodd and DeWine and I will introduce it in the coming days. You have probably already summarized it adequately, Senator, but the bill does authorize $25 million per year in grants to organizations to implement suicide early intervention and prevention strategies in schools, juvenile justice systems, substance abuse programs, mental health programs, foster care programs, and other support entities.

The second piece of legislation you are also a party to and it is the Reed-DeWine-Smith Bill, the Campus Care and Counseling Act. It is a competitive grant program for colleges to create or expand improved mental and behavioral health services for students. The University of Oregon's example is just one example of how effective that could be.

Last, let me tell you for the Senate record why gratitude for Garrett helps me to cope with the grief that comes with losing him. Sharon and I adopted Garrett a few days after his birth. He was such a handsome baby boy, unusually happy and playful. And he was also especially thoughtful of everyone around him as he grew older. His exuberance for life, however, began to dim in his elementary years. He struggled to spell. His reading and writing were stuck in the rudiments. We had him tested and were surprised to learn that he had an unusually high IQ, but with a severe overlay of learning disabilities, including dyslexia.

His struggles in school increased while his self-worth decreased, but his efforts were as big as his heart. He would often do homework with his mother late into the night and then express his appreciation to her for being an "awesome mom," then cry himself to sleep out of fear that he could not compete in school or provide for a family in life. Despite our reassurances of his many redeeming qualities, his self-confidence was crippled in his youth. Though this was apparent only to those closest to him. Everyone else saw a happy boy with a beautiful smile.

Garrett could never hit a curveball, but he was a hit with his friends. That big smile and generous spirit allowed him to befriend everyone, popular or not. Wisely or not, his mother and I showered him with creature comforts as yet another way to show him that we loved him and valued him, only to find out later that much of what we the gave him he gave away to others less fortunate.

Garrett struggled on in school and in Scouting. He became an Eagle Scout and through Herculean effort, seen mostly by his mother, he accomplished one of his two lifetime goals, a high school diploma. His other goal he fulfilled by qualifying to serve a 2-year mission to England for the Church of Jesus Christ of Latter-day

Saints. He loved the camaraderie of his mission companions and he loved his church and his Savior and the chance of serving others.

Yet through all of this we saw Garrett go through periods of dangerous mental darkness. He would withdraw from us and no rational persuasion on our part could draw him back to us. But inexplicably, in fact usually, he would come up in the mornings as happy as a lark.

We sought out help from school and church counselors, psychologists, and, ultimately, a psychiatrist. But words of encouragement, prayers earnestly offered, and the latest in medical prescriptions could not repair our son's hard-wiring defects. Garrett's bipolar condition was a cancer to him as lethal as leukemia to another. It filled his spirit with hopelessness and clouded his future in darkness. He saw only despair ahead and felt only pain in the present.

In his last words to us he wrote "If it is any consolation, your love is the only thing in my life I know will never change. I just wish I could feel the same about myself. I love you so much. And just think, your son will not feel that every day pain anymore."

As Norman Maclean wrote in his poignant family story A River Runs Through It "And so it is those we live with and live and should know who elude us."

That Garrett eluded me haunts me every day and no doubt will for the rest of my days. But this much I know, that he was a beautiful boy, and I loved him completely without completely understanding him.

Thank you Mr. Chairman.

Senator DEWINE. Gordon, thank you very much. Gordon and Sharon, thank you very much for being with us and sharing Garrett with us.

Those of us who have lost children, I think, want others to remember them and also want to make some meaning out of their death. But more important, make a meaning out of their life. I think you are doing that.

By sharing your experience, you clearly are doing an awful lot of good. I think, Gordon, your story about the university and the number of students who came forward immediately is very instructive. The fact that you had the courage and the wisdom to share with people the fact of his suicide, I am sure has done a lot of good and it has been a teaching tool for people.

I wonder if you could maybe reflect on that a little bit about the fact that more information is probably needed in this area? And what does information do for people? Just the information of thinking about it and knowing about it.

Senator SMITH. I think information is an invitation for people that it is okay to get help. I think for so long we have regarded as a society suicide as so aberrational that it is to be shunned and not enough has gone into understanding the why. I believe our understandings of mental illnesses and of depression are at so rudimentary a stage that we have much to learn through research, through study, through outreach, but mostly through an invitation to people who contemplate suicide that it is okay, it is encouraged, it is necessary for them to come in and get help.

Because while not all people with bipolar conditions or manic depression disorders can be helped, many can and live their lives

fully. I think the more we can do to identify them and to help them in a proactive and intervention way, the more we will do our responsibility in the public square.

We were so numb the morning after Garrett's death that we just, without much forethought, just said let us just tell people what happened. Let us not run away from it. Let us try to make some meaning, take some meaning from this. That is why we announced it just as the facts were. And it is enormously encouraging to us that so many students at the University of Oregon apparently felt the need to reach out and to get help.

We need to be there so there is something for them to reach to. And that is why I think the bill, as it relates to colleges, is so important because this is a period of time in young people's lives where they are under a special mental duress as they contemplate careers and providing for family and whether they can compete, whether they can get a job, whether they can make their way in the world.

And I think that is why psychological and even psychiatric help to reach back on college campuses could be so very, very important and lifesaving.

Senator DEWINE. I wonder if you could expand on your description of this new, screening process or program that you have funded for the local students in your area?

Senator SMITH. We were able to raise, with the help of even some of you, Senator Kennedy in particular and his wife Vicki were very generous to this fund we established. We raised over $70,000. And what is necessary for school systems is to have the computers and the software and then to reach out to parents and get permission to test their sixth graders because there are, through this Columbia University teen screening program, there is a very high success rate at identifying children susceptible to depression, suicide and learning disorders that lead to these things.

One of your witnesses on the next panel, Laurie Flynn, will discuss this. As we considered all the options for how to utilize this money effectively, we went to what works. That apparently is what works.

So at least for our community, this fund will be used in perpetuity and administered by St. Anthony's with our public schools to help identifying children in one small town in rural Oregon. Perhaps if Garrett's tragedy has any meaning it will be because we prevent other kids from a similar fate.

Senator DEWINE. Thank you. Let me now turn to Senator Kennedy. Ted, I did not know if you had an opening statement.

Senator KENNEDY. Mr. Chairman, I think all of us are overwhelmed by the presentation. Thank you.

Senator DEWINE. Thank you. Senator Dodd?

Senator DODD. Just again, just to both of you, thank you immensely. And as I said, just by your presence here today and talking about this, we can talk about bills and amendments and things. Do not underestimate your continuing willingness to be a part of a public debate and discussion on this. I know it is difficult. It is difficult for us up here. I cannot imagine the difficulty it is to be here and talk about this.

So just know it has great value and we really, really appreciate it. I have a feeling we are going to get this bill done. We may not get much else in this session of Congress, but I have a feeling we are going to get this legislation passed, Mr. Chairman.

So thank you both for being here.

Senator DEWINE. Senator Kennedy, any questions?

Senator KENNEDY. No.

Senator DEWINE. Senator Harkin?

Senator HARKIN. I do not have any questions. I just thank you both again for your strength and your courage. You are just both good human beings. Thank you for that.

Senator DEWINE. Senator Clinton?

Senator CLINTON. No, thank you, Mr. Chairman.

Senator DEWINE. Again, thank you both for being with us. We appreciate it very much.

As Senator Dodd said, working together, let us get this piece of legislation done.

Senator SMITH. Count me as one of your soldiers.

Senator DEWINE. We will follow your lead. Thank you, Gordon.

Senator DEWINE. Let me introduce our next panel.

Senator Kennedy, did you want to introduce the first member of the next panel?

Senator KENNEDY. Thank you very much, Mr. Chairman. If I could put my full statement in the record, and I appreciate just so much that you and Senator Dodd are having these hearings and for your initiatives. It is a very overwhelming kind of presentation that we have just heard.

We are fortunate in our next panel to have a very distinguished group. One is Father Paul Tunkle, who is a native of New York City and rector of the Church of the Redeemer in Baltimore and earned a doctor of ministry from a school of theology at Drew University.

Father Tunkle has three children. One of them died in 1997 at the age of 22, and his involvement postsuicide intervention and prevention began a year later in 1998. And he and his wife had begun to facilitate support groups for survivors of suicide in Louisiana and Maryland.

In August of 2002, he and his family participated in a 26 mile walk for suicide awareness and prevention in Washington, DC. It was at this walk that he began working on the documentary of the Discovery Channel, Surviving Suicide: Those Left Behind. And the documentary is in line is broadcast during 2004.

Father Tunkle, we thank you very much for joining us today and we look forward to your testimony.

Senator DEWINE. Let me also introduce Dr. Cheryl Ann King. Dr. King is a Licensed Clinical Psychologist and Associate Professor of Psychology at the University of Michigan. She also serves as Director of the Child and Adolescent Program at the University's Depression Center and is Chief Psychologist in the Department of Psychiatry at the University of Michigan Medical School.

For the past 15 years Dr. King has focused on the problem of youth suicide and has devoted the majority of her clinical research to this devastating problem. We welcome Dr. King.

Third, I would like to introduce Joelle Reizes. Ms. Reizes is the Director of External Relations for Screening for Mental Health. She was instrumental in transforming this nonprofit organization into a leading mental health screening organization. Screening for Mental Health was responsible for creating the first-ever National Alcohol Screening Day and has also developed the SOS High School Suicide Prevention Program.

She has overseen the production and development of the Screening for Mental Health educational videos including SOS, Suicide Prevention Training and has authored educational brochures, some of which have been distributed to more than 7,000 sites nationwide.

Let me also introduced Laurie Flynn. Mrs. Flynn is the Director of the Carmel Hill Center for Early Diagnosis and Treatment in the Division of Child and Adolescent Psychiatry at Columbia University. She is also currently serving as the National Director of Positive Action for Teen Health.

Before joining Columbia University in 2001, Mrs. Flynn served as the Executive Director of the National Alliance for the Mentally Ill for 16 years. She is a member of many National advisory boards and professional association committees, including the Clinical Trial Advisory Group and the Research Center on Managed Care for Psychiatric Disorders.

Mrs. Flynn is the author of several articles and books on health services for the mentally ill and family support and was presented with a CNS award for outstanding service to humanity in the year 2000.

Finally, we would like to introduce Fran Gatlin. Ms. Gatlin is currently in her 29th year as a practicing school psychologist and her 27th year in the Fairfax County, Virginia public schools. She has been named psychologist of the year in the school system with more than 168,000 students.

She has a masters of arts degree in educational psychology. Ms. Gatlin is a member of the National Association of School Psychologists and the American Association of Suicidology.

Ms. Gatlin has provided invaluable leadership in implementing school-based suicide prevention programs and is currently serving on a task force with the Fairfax Partnership for Youth to increase suicide prevention efforts across Fairfax County.

Father Tunkle, we will start with you. Thank you very much for joining us.

STATEMENTS OF REVEREND PAUL D. TUNKLE, PH.D., RECTOR, THE EPISCOPAL CHURCH OF THE REDEEMER, BALTIMORE, MD; CHERYL A. KING, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF MICHIGAN, ANN ARBOR, MI; FRAN M. GATLIN, SCHOOL PSYCHOLOGIST, ROBINSON HIGH SCHOOL, FAIRFAX, VA; JOELLE M. REIZES, MA, DIRECTOR OF EXTERNAL RELATIONS, SCREENING FOR MENTAL HEALTH, LOVELAND, OH; AND LAURIE FLYNN, DIRECTOR, THE CARMEL HILL CENTER FOR EARLY DIAGNOSIS AND TREATMENT, NEW YORK, NY

Reverend TUNKLE. Thank you. I appreciate the opportunity to give testimony before this committee.

I would like to introduce myself, which will explain a great deal about my experience and perspective.

On August 22nd, 1997 my daughter, Alethea Rose Mary Tunkle, died of a self-inflicted gunshot wound to the head. She was 22 years old. The tragedy and trauma of my child's suicide has become one of the defining moments of my life.

My wife, Judy, who is here with me today, and I have been married for 32 years. We have three children. Sam is 30 and is a surgery resident in Florida. Elizabeth is 26 and a student in San Francisco. Lea is our middle child.

I am an Episcopal priest serving a congregation in Baltimore, MD. Judy is a psychotherapist.

First, some background and then some observations for your consideration. Lea exhibited psychological problems when she was a grade school student. In retrospect, these symptoms were of childhood depression. Over a 5 year period on two separate occasions, we engaged in work with a professional therapist. On each occasion Lea was identified as the red flag and we were encouraged to work on her family communication skills. Each time we agreed but asked the therapist to work with Lea because of her special problems. On both occasions, she was not identified as a primary concern. They just missed it, twice.

In her early teens she was compliant and academically excellent. She caused little trouble and we were content. She was recruited for the biochemical engineering program at Rutgers University and we were thrilled.

We moved to Louisiana as she began her studies at Rutgers in New Jersey. Her progress slowed and her grades began to suffer. I called the dean of her school to inquire about her progress. I was told that since she was an adult, he could not discuss her grades with me. I shared that I was concerned and he was unable to respond.

I told him I would fly up and that Lea and I would make an appointment to see him. I called Lea and told her I was coming so we could see her dean and visit a psychologist at the university. Between that phone call and my scheduled trip, Lea attempted suicide for the first time. She overdosed on a large quantity of prescription drugs, some of which she stole from her roommates. She left a note which was a clear statement of I am miserable and I want out of here. This is not because you are bad parents. Please forgive me.

The university was unable to help us, even when I asked for it. Lea was a victim of rape while at college. She found no one who would help her. She held on to her shame guilt and it added to her problems. We were unaware of these events until much later.

On her first attempt, she was hospitalized. When she came out of her coma, she was furious as she realized she was still alive. She refused treatment and we had her involuntarily committed to a psychiatric hospital. Our insurance company funded a 72-hour stay.

She was released into our custody while she was still at serious risk for self-harm. Our insurance company would not help Lea to get the treatment she needed. Lea was willing to stay and even re-

quested this. They denied the benefits and Judy and I had no financial means to enable this to happen on a private pay basis.

Lea came home with us for a while and then returned to school. She worked with a therapist but did not improve or remain committed. Each time she was tested she was not diagnosed as clinically depressed and no meds were prescribed.

Several months later, Lea attempted again. She got a hotel room and assembled the drugs and knives to use. Her college roommate and her sister got wind of her plan and traced her. The police came and agreed not to arrest her if she would voluntarily go to the hospital. She agreed.

At the hospital in New Brunswick she waited a long time to be seen, was given a cursory exam, and immediately released while still hallucinating from the drugs she had already ingested. She called us and we arranged to bring her back to Louisiana.

She came home and was increasingly erratic in her behavior. She had a violent range episode and did some physical damage to our home. She left abruptly, induced her younger sister to leave with her, and flew back to New Brunswick. She was operating on credit cards that were freely offered to her as a college student. Again, she was out of control and neither our insurance company nor our resources, nor the resources of the university seemed to be able to make a difference.

Finally, she came home and slowly declined. We arranged for an outpatient treatment program. Lea was asked to leave the program because she was noncompliant. Of course, her illness made her that way but the program seemed unable to handle sick people.

In the end, she went out and purchased a handgun and ammunition. Even though she had been hospitalized for psychiatric problems and had two previous suicide attempts, she had no impediment to purchasing a handgun. She ended her life alone and in desperation.

When I consider all that could be done for young people like Lea, I am moved to reconsider her journey. I believe we need well-trained counselors available to young people all along their path. We need teachers who have been trained to identify young people at risk and to work with their parents. We need colleges to have resources in place for the shocking number of young people who suffer from depression, anxiety, and who are victims of date rape that go unreported.

We need not be afraid of the word suicide nor should we think it is contagious. However, it should be noted that a suicide survivor, namely one who has lost a loved one to suicide, is nine times more likely to die from suicide than the general population. So people like me are an already identified risk group. So are siblings of young people. So are their classmates and friends. They need to talk about their experience, to revisit their trauma, and to feel in that sharing.

Lea had friends who were and continue to be deeply affected by her death. They are among the many who can benefit from professional help.

I am an ordained minister. In the congregation I served Lea died, the leaders became so disturbed by her suicide that they asked for my resignation. Their basic statement was that if my child had

died from suicide, my credentials to be their ordained leader had been invalidated. The fear and pain were more than they could stand. They decided running away was better than facing the depth of the tragedy and growing from it.

I sought the help of my bishop, who intervened and ruled in my favor. But the lesson is that people with good intentions can make things worse when they lack knowledge and information and training.

Judy and I are now training clergy and lay youth leaders in my current diocese on youth suicide prevention skills. Survivors such as us have great credibility among those who are willing to learn.

Lea's death would be even more tragic if we could not use its lessons to help others. We were not bad parents. She did not have bad teachers. Her therapists could have been more knowledgeable and proactive but there is so much that we do not understand. One of the best things we can do is to open the discussion and the dialogue. We can let young people know there are those who will understand and will want to help. We can underscore that they need not travel the path of despair and depression alone. We can help the general population know that suicide is like leukemia. It is a disease that needs compassion and treatment, not shame and guilt.

If Lea could be here she would say please, stop and listen to me. I am frightened of what is happening to me and I need for someone to know and to understand. I do not want to die, but I need to know it will not be like this forever. Can you help me? Can you love me even though I think I want to die? Can you save me from this?

How I wish I could have heard her and responded better. How I wish she had found those compassionate and understanding voices when she was a little child, when she was a teenager, and when she was a college student. Maybe through your efforts others will not have to die like Lea. We lost not only our daughter but all the future potential she held for a life filled with blessing and joy.

Let us do all that we can to save our children. As our culture becomes increasingly complex and pressured, our children need more help than ever finding their way. Let us be part of that helping system, turning them from the darkness back toward the light of life.

Thank you.

[The prepared statement of Reverend Tunkle may be found in additional material.]

Senator DEWINE. Father, thank you very much. Dr. King?

Ms. KING. Good morning, Chairman DeWine and Members of the Subcommittee and thank you for inviting me here today.

The number of youth who commit suicide in our country is alarming and I applaud you for taking the lead in addressing this tragedy.

A series of highly visible events have created an historic juncture for suicide prevention efforts. These were catalyzed in 1999 when the Surgeon General's call to action to prevent suicide stressed the need for effective suicide prevention strategies.

In 2002, the Institute of Medicine published Reducing Suicide: A National Imperative. And even more recently, the report of the President's new Freedom Commission on Mental Health stressed

the urgent need for action on suicide prevention. Now is the time and this is the year that we should take action.

Just to highlight a couple of the major things we know about youth suicide that really can guide our prevention efforts. As Senator DeWine noted, completed suicide is much more common among adolescent males than females in the United States. It is a five to one ratio. And even the strategies that we are beginning to develop are showing more effectiveness for girls. We desperately need research on effective suicide prevention strategies for adolescent males.

Despite that, the reverse is true for thoughts of suicide and suicide attempts. These are almost twice as common among adolescent girls than boys in our Nation. Although it is not the strategy of completed suicide, these attempts are associated with severe mental disorders often. Serious psychological pain and trauma for these adolescent and their families and a great deal of impairment and multiple hospitalizations. We also need to prevent these repeated suicide attempts that interrupts children's lives.

In terms of primary risk factors, there are many but there are a couple of primary risk factors that have already been highlighted this morning. What we know about these will guide our efforts.

The first is that the single strongest predictor of a suicide attempt or completed suicide is a previous suicide attempt or previous suicidal behavior. Moreover, a family history of suicidal behavior substantially increases the risk of suicidal behavior and suicide in young people.

Mental disorders. About 90 percent of all youth suicide victims have histories of identifiable mental disorder. The most common types we began to hear about already this morning, depressive disorders including bipolar disorder, alcohol and substance abuse and conduct disorder or patterns of aggressive behavior. It may be possible to prevent the onset of some types of disorder such as alcohol and substance abuse. For other disorders, such as depressive disorders and bipolar disorder, early identification, screening, referral and the availability of effective services are both urgently needed and feasible.

So the primary risk factors are a previous history of suicidal behavior and the presence of mental disorder.

Firearms are the most common method of suicide in the United States for both boys and girls. In one study, firearms were present in the homes of 74 percent of adolescent suicide victims versus 34 percent of hospitalized adolescents who made suicide attempts and survived them. Because suicidal youth may be impulsive or ambivalent about killing themselves, they may be under the influence of alcohol when they make suicide attempts, the risk period, the period for the most imminent risk, is often short-lived. It occurs within a window of time. Restricting access to the most lethal means from which there is the return, no chance for hospitalization, and no chance for treatment is an extremely important prevention strategy.

Much still needs to be done to prevent youth suicide. Few randomized controlled treatment or intervention trials have ever been conducted with suicidal youth. We need to develop effective strate-

gies to intervene with those who reported thoughts of suicide and those who have come to our attention following a suicide attempt.

Yet a comprehensive plan for suicide prevention in our Nation should include multiple points for prevention, maximizing the likelihood of reaching youth in need. Universal preventive interventions are directed at the entire population. These might include educational public service announcements about depression and the recognition of depression, restrictions on advertising for alcoholic beverages. It might include school-based health classes that emphasize mental health and substance abuse problems or health promotion activities.

Selective interventions would include those that are specifically designed for high risk youth. The school context, which has already been talked about this morning, has the potential to be a very important place to identify and secure help for at-risk children. An educated school environment with an awareness of the signs of depression and suicide risk among students, teachers and others can create a safety net for recognition and referral.

I would also like to take this opportunity to commend several members of the subcommittee for the efforts to address the increasing incidents of depression and suicide among our Nation's college students. A Senate companion bill to H.R. 3593, introduced by Congressmen Davis of Illinois and Osborne of Nebraska could help to save lives. The bill proposes to amend the Higher Education Act by providing funding to increase access to mental and behavioral health services on college campuses. The bill addresses the increasing numbers of students at our colleges who are seeking services and the increasing severity of their needs which has moved far beyond academic counseling.

This is extraordinarily important. Recognition and referral, screening. There are strong screening programs and it can be a very positive strategy. But recognition and referral is only the first step. We must have services available for those who are referred for services.

Federal agencies play an instrumental role in helping to address this National tragedy. The Centers for Disease Control and Prevention has demonstrated great commitment to reduce youth suicide rates through an array of initiatives. The National Institute of Mental Health continues to develop and test various interventions to prevent suicide, such as through early diagnosis and treatment of depression and other mental disorders. With funding from the National Institute of Mental Health, I am developing and evaluating a new youth suicide prevention strategy which is called YST, the Youth-nominated Support Team. This supplements usual mental health services for acutely suicidal youth by building an informed, educated network of adults to support them.

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration also continues to provide critically needed mental health promotion and youth suicide prevention services.

In sum, the development and implementation of an overarching strategic plan for suicide prevention can be achieved with the shared vision, commitment and resources of disciplines and Government working with individuals and communities.

Thank you again for the opportunity to present this testimony. I would be more than pleased to answer any questions.

[The prepared statement of Ms. King may be found in additional material.]

Senator DEWINE. Dr. King, thank you very much.

Ms. Reizes?

Ms. REIZES. Thank you very much, Mr. Chairman, Members of the Committee.

I am pleased to be here today to discuss a critically important public health issue, teen suicide. I am the Director of External Relations for Screening for Mental Health, a nonprofit organization based in Wellesley Hills, Massachusetts. I operate a satellite office in Loveland, Ohio.

Screening for Mental Health's mission is to promote mental health screening as an integral part of overall health care. Our teen suicide prevention program is called the SOS High School Suicide Prevention Program. According to the National Center for Health Statistics, suicide is the third leading cause of death in the 15- to 24-year-old age group. Indeed, one in eight adolescents between the ages of 15 through 19 will suffer from major depression in any given year.

By way of introduction, I want to pass along a story that was related to me just last month by a school counselor from Cape Cod, Massachusetts. She ran the SOS program in her school last year. As a result, a young man recognized his own symptoms and came to the guidance counselor for help. The guidance counselor contacted his parents and together they got him the therapy he needed. A year later, he is doing very well and succeeding in school.

But 2 weeks ago, this same young man went to class, sat down in his chair, and noticed that the student who had been sitting there before him had written on the desk I felt terrible and want to kill myself.

Because he had been through the SOS program, this student knew to take this note seriously. He also knew who to go to for help. He alerted the school counselor who was able to work with the teacher's seating charts to identify the student in need. It turns out this young person was actively suicidal. The counselor contacted the parents and got the student into the local hospital to be evaluated that same day.

This potentially lifesaving intervention resulted from increased awareness achieved through the SOS program. SOS provides a mental health check-up via depression screening. It also provides the education teens need to recognize depressive symptoms in themselves or others and the power to act when they see these symptoms. This means that even if the student is not depressed or suicidal at the top of the screening, he or she will know how to recognize the symptoms and what to do to get help if it ever does develop in the future.

The main teaching components of SOS are the depression screening questionnaire and an educational video with discussion guide. The video, entitled Friends For Life, features dramatized vignettes that model the wrong and the right ways to react to a friend exhibiting suicidal signs.

Schools that want to participate in the SOS program register with the Screening for Mental Health office. Screening for Mental Health then sends each school a huge box of materials which we call a screening kit. This kit contains everything the schools needs to implement the program, including procedure and training materials for school personnel, depression screening forms, the Friends for Life video, posters, and a variety of educational brochures. School health professionals and local clinicians implement the program, creating a team and setting up referral procedures based on local resources.

Most schools learn about the program through one of several professional associations. SOS enjoys the support of the National Association of School Psychologists, the American School Counselors Association, the National Association of Secondary School Principals, and many other school-based and mental health organizations. Members of these organizations serve on our advisory board and, in fact, were instrumental in the development of the program from its very beginning.

This is one of the reasons the SOS program is successful, because before we created any materials, we involved these groups and asked them what they wanted in a suicide prevention program. SOS was designed with the input of the very same school nurses, counselors, school psychologists who actually do the work with the students in the schools every day.

A landmark study conducted by Dr. Robert Aseltine of the University of Connecticut Health Center will be released tomorrow in the American Journal of Public Health. This was a randomized controlled study with 2,100 students from five high schools and it revealed a 40 percent decrease in suicidal behavior, suicide attempts, in exposed to our program.

This Nation has an over 20-year history with school-based suicide prevention programs and yet this is the first time anyone has ever seen this kind of result. This groundbreaking data is part of the reason why the SOS program is the only suicide prevention program currently listed on SAMHSA's National Registry of Effective Programs.

SOS is also cost-effective. Our current per child cost is only $1.

We hope to grow the SOS program with Federal support so we can provide the program to as many schools as want it. The program is cost-effective, flexible, easily reproduced in a variety of school settings, and the only program to have evidence of its ability to reduce suicidal behavior. We believe this is an important program option for schools looking to do suicide prevention programming.

But most importantly, we simply believe that our children are worth the investment.

Thank you very much for your time and attention, and I would be happy to answer any questions.

[The prepared statement of Ms. Reizes may be found in additional material.]

Senator DEWINE. Thank you very much. Mrs. Flynn?

Ms. FLYNN. Thank you. Thank you, Mr. Chairman and Members of the Subcommittee. I am very honored to be able to participate

today as a witness in this very important, very moving hearing on youth suicide prevention.

As for so many here, this issue is personal to me. My oldest daughter made a very serious suicide attempt during her senior year in high school. She was the valedictorian of her class and had starred in school musical and had every sign of moving on to a successful career.

And frankly, as a parent I had no warning. I had no sense that there was any danger. Very rapidly she deteriorated. She made a serious attempt. Thank God she was saved.

But it was, for me, the single most terrifying experience of my life. And I have been dedicated since that time to doing anything I can to prevent these kinds of tragedies which, as we have heard from Senator Smith and Father Tunkle, continue to have a devastating effect on families and communities.

Happily in a hearing on such a difficult topic, there is, as we have been hearing, real hope for some real advances in prevention through early identification and treatment. I am very delighted to be able to share with you the work we are doing at Columbia University, which is based solidly in research that has been going on for more than a decade.

We believe that this growing body of science indicates that we can indeed find those youngsters who are suffering from mental health problems, often not visible, not easily discerned. We can find these youngsters. We can reduce their risk for suicide. We can indeed help them before they move into all of the related problems, poor academic performance, substance and alcohol use, self-injury, all of the kinds of things that derail these young lives and send families into despair.

So we are delighted to offer, through the Columbia TeenScreen Program, an opportunity to school districts across the country to implement mental health checkups for youth. When you think about it, we as parents want our youngsters to have physical health checkups every year. It is part of being a good parent.

And yet adolescence is the healthiest time of life. And the likelihood of finding, when we put the stethoscope on and listen to the heart, symptoms of a heart problem are quite rare. The likelihood of finding something in a youngster at the time of adolescence that may require and benefit from mental health treatment is not so uncommon.

I am here representing a program based in science pioneered by Dr. David Shaffer, who is Chairman of our Department of Child and Adolescent Psychiatry at Columbia. But I am here principally as an advocate, as an advocate for mental health screening, and as an advocate for families and children across the country.

In my family we have three generations of suicide. This is an issue that is of some urgency, I believe.

The Columbia TeenScreen Program originated in research done principally in New York City and then replicated in Nations across the globe. What we have found is that because we know, through psychological autopsy studies, that suicide and suicidal behavior is, in over 90 percent of the cases, directly related to a psychiatric disorder it stands to reason that if we can identify those at risk or

exhibiting symptoms of psychiatric illness we can indeed intervene and save lives.

Our program has a simple purpose. We want to screen youth for mental illness and we want to identify those who are at risk and, importantly, link them to effective treatment. And indeed, this is a major challenge but it is one that we do not shrink from.

Over the past several years, as we have moved our program from research into service in the community, we have trained over 108 sites. We are now active in 34 states. And as you heard, we are very proud to be part of the memorial in Pendleton, Oregon that has been established for Senator Smith's son, Garrett.

Our program works in a simple way. We create partnerships with communities across the country. We look for those who are interested. We work principally in schools because that is where the kids are. But we are also active in residential and foster care programs, in clinics, in shelters, drop-in centers. We work with Covenant House in Florida. We work with Boystown in Nebraska, anywhere that people care about this problem.

The heart of the program is a brief diagnostic interview screen that is encoded in software that is loaded in a laptop computer. With parental consent, the youngster puts on headphones and hears the questions spoken and sees the questions on the screen. And in a confidential self-administered way is taken through the basic interest and issues that arise in a psychiatric problem.

Happily, because of a very generous benefactor to our university's school of medicine, we at Columbia are able to offer this at no cost to sites across the country. Our staff is completely paid for by our benefactor. We offer the software, the training, the follow-up technical assistance and support to enable schools to move forward and implement the program.

It has been our experience that this is often a critical component. We are able to address the concerns about one more thing, one more cost, one more issue that is competing for attention in schools.

We are pleased that we were highlighted in the recently released report of President Bush's new Freedom Commission on Mental Health. And we have indeed moved from working with communities to looking at state-based implementation to try to leverage some of our early grass roots successes.

So we are working in a number of States, including Ohio, where Commissioner Michael Hogan has taken this program on and provided small grants of $5,000 to $15,000 to mental health boards at the county level. We now have 10 counties in Ohio that are active and we expect to be working with 20 next year.

In Nevada, unlike Ohio where we work with the State mental health department, we are working with the State department of education and the State board of education, building on work that began in Clark County which is one of the largest and fastest growing school districts in the Nation. And as we know, States west of the Mississippi have a higher rate of suicide at every age.

In New Mexico, where there is a high proportion of Native American students, again with uniquely high risk, we have been working with the State department of health and the University of New Mexico Department of Psychiatry to work with school-based health

centers, a structure already in place in many of the local schools, and to work as well with Native American schools in rural parts of the State.

In Connecticut, we are active in both Bridgeport and Wilton. And we will be working, just later this week with the Connecticut Society of Pediatrics, as well as the Psychiatric Society, to see if we can find others to work with us to promote the spread of this program.

We are active in Iowa, where as a result of a high profile suicide of a student at Lincoln High School, former Governor Terry Branstad convened the school superintendents and the area education agencies to work not only to address the issues in the high school's immediate strategy, but also to develop some prevention programs across four different districts in the State.

We are active, as you have heard, as well in Oregon. We are also active in Florida. We are working with the State office of drug control, another potential ally in State government. We are mounting a task force activity in two contiguous counties, Hillsborough and Pinellas, to screen all ninth graders and accompany it with a community partnership to share education, information and support to parents and school officials.

We are very pleased at the flexibility of our program. One of our goals is to engage an ongoing infrastructure already in place, to look at resources both fiscal and professional, that can pick up the program, expand the program, adapt the program and make sure that it reaches its target.

We have been especially pleased to work with Connecticut Representative Rosa DeLauro around the introduction of the Children's Mental Health Screening and Prevention Act, H.R. 3063. We are delighted to participate in the other work being done here in the Senate to address this problem, because indeed we know we can do something to find these kids, to help these kids, and indeed to save these kids.

We have had extensive and positive collaboration with both the Substance Abuse and Mental Health Services Administration to encourage them not to support our program directly but to support these efforts across the country and particularly to name someone in each State who can be a focal point for these actions.

And at the Department of Education——

Senator DEWINE. Ms. Flynn, we are going to have to conclude.

Ms. FLYNN. Thank you. Thank you very much.

[The prepared statement of Ms. Flynn may be found in additional material.]

Senator DEWINE. Thank you. Ms. Gatlin?

Ms. GATLIN. Thank you.

I am a school psychologist and I work in a high school with 3,000 students in Fairfax County, Virginia.

The role of schools in the identification of student mental health needs cannot be overestimated. Schools are a critical component in effective mental health care of children and adolescence. We have the opportunity to observe students at risk and direct them and their families to appropriate mental health treatment.

We can educate them about the signs and treatments for suicide risk and other mental health problems. And as we are learning is so important, we can help them understand the vital role that they

play in saving the life of a friend or classmate by telling an adult when they believe a peer is at risk.

But we need resources to do this work.

In my State of Virginia the rate of suicide among high school aged youth is about one per week. As former Surgeon General Dr. David Satcher said, suicide is the most preventable form of death but it requires an investment to save these lives. The public needs to be educated about suicide. People need to understand that most suicide results from untreated depression and that depression is treatable.

Surveys tell us that one in five teenagers seriously considers suicide. 520,000 teenagers require medical services as a result of suicide attempts each year. Psychological pain implied in these numbers is staggering. Unfortunately, most parents are in denial that these issues could affect their families.

Talking to students is a central part of any suicide prevention effort. I learned early on that of teens who kill themselves, 80 percent tell somebody before they die. But the person they tell is another adolescent, not an adult, not someone likely to take action on their behalf.

Six years ago I began doing a lesson in all 10th grade health classes at my school on signs of adolescent depression and suicide. My message to these teens is that they may be the only one who knows that a friend is depressed and potentially suicidal. And that they have to tell an adult in order to save a life. I learned since that this is called peer gatekeeper training.

I also offer a mental health support group at my school for students who have had a suicide attempt or a psychiatric hospitalization. These are the people at the highest risk for a suicide attempt since they have already taken that action. Such school-based support groups function both to provide mental health services but also to keep a watchful eye on the most vulnerable of populations.

I should interject that this group has included a valedictorian, a recruit to a Big Ten football program and many bright and talented individuals. Depression and suicidal feelings can affect anyone and disproportionately impact highly intelligent and creative people.

Identifying students at risk is an important part of suicide prevention efforts. After being a volunteer screener on National Depression Screening Day for several years, I was able to initiate depression screening at my high school when the Signs of Suicide Program became available. Many students have been helped in the years we have used it.

Screening and assessments are critical to effective suicide prevention. They need, however, to be fit into a comprehensive suicide prevention program. Education of parents and students, successful referral to effective treatments, and the availability of knowledgeable mental health professionals within the school environment are all key to effective suicide prevention.

Teens do not generally have access independently to mental health services. Increased access to school-based mental health services is vital to improve suicide prevention. As the National Institute of Mental Health indicates, of some 7.5 million children under the age of 18 requiring mental health services only one in five receives needed services. This statistic has not only alarming

implications for suicide rates but for other dangerous behaviors as well. We are seeing a dramatic increase in students engaging in intentional self-injury and in substance abuse.

The use of alcohol and drugs is such a significant factor in teen suicide. Fifty percent of teens who die by suicide are legally drunk or high at the time of their death. The disinhibiting effects of the alcohol or drugs may be the dynamic that tips the scale from life to death.

I believe that any effort to ensure that our schools are safe and drug-free must also include school-based mental health services to address the great needs of these students.

Another significant risk factor for teen suicide is access to firearms. Nearly two-thirds of teens who die by suicide use firearms. And we know from a number of studies that restricting access to immediately lethal means save lives.

Thank you, Senators, for supporting Senate Bill 1807, to close the gun show loophole and hopefully prevent juveniles from buying firearms at gun shows.

Schools have another significant advantage in helping to prevent suicides, that is familiarity to and access with the family and friends. Because suicide does leave a legacy of suicide, the immediate family and friends are nine times more likely to die by suicide.

Five years ago, my school year began with the suicide deaths of two students at my school in a 3-week period. As a result, I joined the American Association of Suicidology. I offered a support group to the friends of the deceased students. Helping these teens deal with the death and understand it as an unfortunate choice will hopefully keep them from ever making that same choice. It was reassuring and rewarding when they were able to reach a point of remembering the life of their friends instead of being stuck in the horror of such an unnecessary death.

The President's new Freedom Commission on Mental Health indicates the need for schools to play a crucial role in identifying students in need of mental health treatment as well as linking them to services. I am in wholehearted agreement. Our linkages between school and community-based services need to be enhanced. The health and well-being of our next generations depend on our capacity to do effective suicide prevention, education and services.

On behalf of the National Association of School Psychologists, I thank you for the opportunity to speak to this important matter.

[The prepared statement of Ms. Gatlin may be found in additional material.]

Senator DEWINE. Great.

This has been a wonderful panel. I just frankly wish every member of the U.S. Senate would have had the opportunity that we have all had this morning to listen to all of you.

I just have one question before I turn to the other members of the panel. Father, you talked about, in your testimony, in regards to your daughter, about the college she attended, the university she attended, which raises—and Dr. King, you talked about it as well—raises the issue of how well our universities are doing in providing services.

And I wonder if you could, members of the panel, if any of you would like to discuss that, and what else we could do at the university level. Father, you talked about the fact that they could not talk to you, I guess, which is a basic problem now that we look at young people when they turn 18 as adults. That is a problem. They cannot give you a warning, I guess, if there is a problem.

How well are the universities doing, or colleges doing? And what else can we do? What else can they do? What can we do to help them?

Ms. KING. Across the Nation I think it is fairly consistent that they are not doing very well with this right now because the history of these university and college counseling centers really was a different mission, and that was to provide academic counseling and help with the adjustment away from home. It really was not to deal, nor are they staffed anywhere to my knowledge, to deal with bipolar disorder, major depressive disorder, someone who has made multiple suicide attempts. And yet, these other services are not usually readily available to all youth when they are away from home.

So I think one possibility is we do think of screening, that several people have talked about, as one component in a comprehensive program, but it is not sufficient as a sole intervention or sole strategy because, of course, not all youth or college students will voluntarily participate in the screening. They may not all acknowledge these problems because of real stigma that they are concerned about.

And when identified, it is only a subset of those who screen positives who actually end up getting services. So that is very important in terms of identifying and getting some of the youth to services.

I think what we also need at the colleges and universities is a greater awareness among the counseling and other staff, perhaps the professors. That is a tough one. This works better in the school settings where you can teach the personnel who know the kids, the students, about risk factors.

But the availability of services, in addition to screening, is really what we need to have at the colleges. It may be redefining the mission of the campus counseling centers or finding some other way of filling the gap of the absence of service for the more severely mentally ill college students.

Senator DEWINE. Anybody else?

Reverend TUNKLE. I think parents could also benefit from having college professionals give them some guidance during the orientation process when they bring their children to college, on how parents can be partners with the school in looking for risk factors with their children and being proactive in that score as well. Parents are often clueless and could benefit from some guidance.

Senator DEWINE. Ms. Reizes?

Ms. REIZES. Thank you. I would just like to say that in addition to the teen suicide program that I talked about here, Screening for Mental Health does run a very large college program called College Response. And it is, again, to do what Dr. King is talking about, provide colleges with the opportunity and the tools they need to participate in National Depression Screening Day, for example, and

to hold an event on campus like a health fair where they can offer screening and provide educational outreach. As well as we also provide, as part of this, an interactive screening that can be embedded in the college's website so that there is ongoing screening presence 24 hours a day, 7 days a week, with specific referral back to that college's counseling center. We have about 700 or so colleges that participate in that.

Senator DEWINE. Good.

Senator Dodd?

Senator DODD. Thanks very much, Mr. Chairman.

I have so many questions for all of you. I cannot thank you enough for your testimony.

I was saying to the chairman, I kind of regret that we do not have more public viewing of what you are saying here. We normally have C-SPAN and others that cover these hearings. And I am trying to figure out some way to disseminate some of what you had to say here that is tremendously worthwhile. I thank all of you for being here.

Let me jump to a question. I have a lot of other questions that get to the issues of the studies being done. Ms. Flynn, whatever help we can offer you in Connecticut, please let us know today or tomorrow where else we can help you with some of these studies that are being done.

And Ms. Reizes, I appreciate your comments about the Hartford Public School System. They have done a great job with this and I am very anxious to see the study.

I want to get if, I can, to the use of some of the medications. Neighbors of mine here in Washington, wonderful people and great, great friends of ours, have a daughter, who made at least one or two attempts on her own life, but today is doing tremendously well and is a teacher. We were just talking about it the other night, we had dinner together, not in preparation for this hearing but just fascinated by what they went through as a family.

And one of the problems they had was the medications that were being provided. And there was a question about whether or not there was a proper dosage medication or combination of medications.

I do not know to which one of you, maybe Dr. King or others here who feel competent talking about this, but I would like you to address it to some degree.

We have sent a letter, Mr. Chairman, in the last day or so to the Food and Drug Administration. My colleagues here, Senator Kennedy, Senator Clinton, Senator Murray, Senator Bingaman, Senator Harkin, Edwards, Corzine, Johnson, and Mikulski have all signed on, asking the FDA to look at this issue. We recently passed—in fact, the chairman was tremendously helpful on this—with our exclusivity rule and then requiring the rule with Senator Clinton's leadership on the testing of these products on children particularly. We have only one product that has been approved by the FDA. There are a variety of others that have raised some serious questions.

Others I very clearly think do a tremendous job and have saved lives. So I am not drawing a conclusion here but I would like to

get your feelings about all of this because it is so tremendously important, it seems, in addressing this issue.

The British recently banned the usage of all of these things. I do not know how wise that was. But I would be very interested in jumping into this subject matter because it is one that I think we need to talk about. And clearly the FDA needs to address this issue.

And we would hope they would do it under the exclusivity rule, but if they do not, then our letter suggests that they order the rule be invoked. There is a debate about the wisdom of that approach, but we think it is an important step to be taken.

So I do not know which one of you feels the most competent to talk about this. Dr. King, let me start with you. You have got doctor in front of your name, so we will start with you.

Ms. KING. I am aware there is an ongoing Federal investigation concerning the use of antidepressants in youth. It is difficult because none of us or none of our sites individually have access to all the data from all the clinical trials using antidepressants with youth. This is a combination of Federally sponsored trials and pharmaceutical company sponsored trials.

As part of the Federal investigation they will be getting all of that data on adverse events that occurred during the trials. I think that is extremely important and we need to wait and hear.

But we do now, in the last several years, have evidence from randomized controlled double-blind placebo controlled studies that antidepressants can be effective with youth. I think that one of the issues though, is that the effect size I think sometimes this is not talked about. It is not tremendous. It is not as large an effect as what we find in studies with adults.

So one of the issues is when you weigh that effect size with the possibility, if that is what we learn, of harm, where will you balance? And that is why we really need to get these findings.

I think the other issue is that it is easy when we have effective antidepressants for many providers to perhaps see that as a sole intervention. The problem is that most suicidal youth, especially the most severely suicidal at risk for completed suicide, often have multiple difficulties in areas of their life. It could be school failure or they might be doing extremely well. And maybe they have a substance abuse problem. So that we often want to see, especially with youth, that even when antidepressants are used effectively that they are used as one part of a comprehensive treatment that takes into account the other possibly serious risk factors for suicide in the youth.

Ms. GATLIN. The funds have not been there to study child and adolescent psychiatric kinds of problems, even within this metropolitan area. There are not an adequate number of child and adolescent psychiatrists available for parents. So they get in to see somebody 15 minutes and somebody gives them a pill and that is a solution.

We need a Mayo Clinic of child and adolescent psychiatry in this country where people can go for the finest minds and the best research being done and so that can be parceled out to the individual psychiatrist back home.

Children are not getting proper care.

Ms. FLYNN. Just to go further with that, certainly at Columbia we are doing some of the analysis and the review is terribly important, as Dr. King has said.

But it is also quite true that most of the youngsters in this country who are being treated for mental disorders are not being seen by child psychiatrists. Quite clearly, one of the things we need is to draw in pediatricians, family physicians, others who are involved in dealing with these medications so they understand them better, can use them more wisely, and can open those important channels of communication with families.

Senator DODD. Do I have time for another question?

Senator DEWINE. Sure.

Senator DODD. Just quickly, let me ask you about the postvention notion. We had a tragedy in my hometown of East Haddam, CT, few years ago that got national attention. A young man took his own life in a car. In fact, in front of the Congregational Church in town, drove into a tree.

Several days later this boy's brother did the same thing, to the same tree, in fact. It received a lot of attention. We are a small town, a small rural town in Connecticut.

And I am fascinated by the notion of the postvention in dealing with families and what happens, and how quickly we move in this area. I wonder if you might comment?

Reverend TUNKLE. I would be glad to comment on that because my wife and I have been involved in this postvention activity. Our exposure to the postvention community in Louisiana, they have been developing a program that brings a survivor group, a trained survivor group, to the scene of a suicide death almost immediately, with the help of the coroner. I have had the opportunity to attend the funeral of a stranger and go up to that stranger at the funeral and say my daughter died from suicide, here is my card. When you are ready to talk, I am here.

We find that when studies are done of people who received this intervention shortly after the death of a loved one, their healing process is greatly enhanced and greatly compressed. And so that is a very important area, as well. Again, if suicide survivors are nine times more at risk than the general public, then this is also a suicide prevention program.

Senator DODD. I am wondering, too, about unintentionally romanticizing of these events among young people and the postvention because of her siblings in this case. But I gather, as you point out Ms. Gatlin, it is not uncommon for other children in the school setting to see this as an example there has been a romanticizing of this event.

Ms. GATLIN. I think we are doing a better job of asking the media not to romanticize, to not report as much about it. Within the school system we work very carefully to identify those at known risk and open up to the population to provide services for anybody who deems themself to be at risk.

You are exactly right, teens are so vulnerable to this romanticism. That is why it is so important, in the talk that I do with them, to link suicide to mental illness, to link it to an ambivalence that they want very much to end the psychological pain they are

feeling. They just, at that moment, see no other way to end the pain without taking their lives.

That kind of message to them changes their thinking and stops the romanticism.

Senator DODD. Any other comment on this point?

Ms. KING. Just that cluster suicides do account for 5 percent of youth suicides and the phenomena of contagion or clustering occurs almost entirely among youth and young adults. So that postvention programs in schools are extraordinarily important.

Also, I just wanted to comment that Louisiana is considered in the Nation to be a model for postvention services for families. It is very well known and Frank Campbell is there and would have tremendous information for your group if you are interested in postvention.

Senator DODD. Thank you, Mr. Chairman.

Senator DEWINE. Senator Kennedy?

Senator KENNEDY. Again, thanks to all of you. It has been enormously informative and very moving testimony here.

I know, Mr. Chairman, we are joined by some young people, some students, in the back here. Welcome to all of them.

I am kind of interested in the panel's view about the change that has taken place in terms of the profile of those that are involved in suicide now. You see, particularly among black youth for example, the percentages and the numbers have been going up very, very high. How is this thing changing, if it has been? I am interested in that.

And second, I am interested in the parents. We have heard from Father Tunkle very moving testimony about how he tried to do the best he could. But also, the role of parenting today and with these kinds of responsibilities, how parents are going to know about it, how they are dealing with it, what is happening with parents? Are they spending enough time with their kids and trying to understand it? Are they too busy doing other things?

How much of that is a force or a factor, as well, in terms of trying to understand and getting a handle on this?

First of all, I would be interested in sort of the faces of the people that are involved in this and how it has altered or changed in the last several years.

We have seen the statistics. It is 180 percent in the last 20 years, black youth, for example. I am just interested in why this is happening? Are there any things that we ought to understand about that? Is that different from some of the things that we have talked about today?

Ms. GATLIN. I think that there is a change among black males. Their increased rate of suicide has gone up greatly. Females, it is not true. Females, among the African-American population, remain very, very low and I think we have a lot to learn from them.

But I think if you take the principle that in the world, the places where the highest rates of suicide occur, are those in which the people are losing their traditional culture and values.

And then take that to the individual group and our communities are being pulled apart. And in some ways perhaps a dynamic in African-American males' life is the loss of some of their traditional

cultural binds. They are left more alone and it is a sense of isolation that feeds into suicide so frequently.

Ms. REIZES. Senator, I cannot particularly comment on why we have seen changes.

What I can say is that our experience with our program is that the same messages work regardless of race. The message, again, should be tied to the idea that suicide is a fatal outcome of a mental illness. And that is the most critical thing we can say again and again.

It is very important that that connection be made and that the idea that mental illness can be treatable and that this does not have to be the way you feel for the rest of your life, that we can work with this.

To answer your question about parents, I think it is important not only to involve parents but to assure them that they did not do this. They did not cause this. Anymore than they cause leukemia, any more than they caused a heart attack. You have to empower the parent to feel like they can help their child and to try to unburden them somewhat of the blame.

In our program what we do is we provide what we call a parental screening form which is actually a version of the same form that the children complete. But it has what we call a lower cut-off, meaning that it makes it a little easier for the parent to figure out whether or not the signs and symptoms of depression or suicide are apparent in their child's behavior or attitudes.

The reason we lower that cut-off is because we do know that so often kids know, parents do not, and the friends do not tell. So we try to provide a screening form in a way that a parent can actually take it to help them think through their child's attitudes and behaviors and really involve them in what the school is doing. And the schools do that when they send out their permission letters and consent letters. So that is one way we can hopefully help educate parents.

Ms. FLYNN. If I might just add one other factor we might want to consider, we have seen over the past 4 or 5 years, and it looks like it is being sustained. a drop in the overall suicide rate for youth, which is positive and may, in fact, be one indicator of greater access and perhaps some positive effect of some of these medications and treatment we were talking about.

We are not seeing that with young African-American males and it may reflect a poorer access to health care.

Senator KENNEDY. OK. Father Tunkle?

Reverend TUNKLE. I think another impediment to effective suicide prevention is the shame and the stigma which has been sort of embedded in our culture regarding suicide. Ironically, that shame and stigma originated perhaps in the life of the early church where it was seen as a suicide prevention program, that early Christians were a little too eager to see themselves done in for the sake of Christ. And the church was so alarmed at the number of people who were signing up to check out for Jesus' sake that they stigmatized it and said if you do this, you are going to lose out on the eternal reward.

So yes, we have made tremendous progress in a couple of thousand years, but this stigma still holds on. I think sometimes young

people have this impediment to stepping forward and saying I need help because it would be easier to ask for help if I had leukemia than if I had self-destructive thoughts.

So a hearing like this, anything we can do to open up this conversation, is tremendously beneficial and I thank you for it.

Senator KENNEDY. Thank you. Thank you, Mr. Chairman.

Senator DEWINE. We have a vote on. This will be a series of votes.

Senator Clinton will ask the last questions. When she is done the hearing will be over and I want to thank each and every one of you.

Senator Clinton?

Senator CLINTON. Thank you very much and I really thank you, Mr. Chairman, for holding this hearing. And I thank all of our panelists.

I do not have a question so much as a comment. I think the work that the panelists have done and the testimony they have provided us today certainly gives us a lot to think about, but also some pathways to follow.

I commend you and Senator Dodd for introducing legislation. But I think we have to recognize that we are looking at larger issues here. Our failure to have mental health parity, our failure to fully fund adolescent mental health programs. In fact, we seem to have a difficult time even recognizing the need for childhood and adolescent mental health treatment.

Our failure to really require that all of the tests that have been done on the serotonin re-uptake inhibitors are put into some kind of registry so that people can have access to the clinical studies and the information so that they can act on it instead of having it just locked away somewhere and be pried open and try then to be put to use.

So I think there is a tremendous opportunity here and I hope that those of you who are on the front lines of this tragic issue will stay with us and be consistent with us in our efforts.

I would add two other groups that I think deserve to be mentioned. There is a consistently high rate of Native American adolescent suicide. And there has been a surprisingly high rate of suicide among our military forces in Iraq. I think that bears some real attention, as well.

Finally, today we will be voting on I am afraid making firearms even more accessible to people who have temporary mental health problems, who have depression, who have either suicidal or homicidal tendencies that could otherwise be reduced or dealt with. But we are going to arm even more of them and I think that is a great tragedy that unfortunately we do not have to have done but we are barely on the way to doing. It will be even more possible for young people to have access to weapons to do away with themselves and others, which I think is obviously a horrible development.

But we have to deal with what we are given. We are going to need even more help to try to screen and support and treat people to avoid those kinds outcomes.

Thank you very much.

Senator DEWINE. Thank you very much.

Let me again thank the panel. It has been very, very instructive. We have learned a lot and we will try to take the information that we have learned today and turn it into some very positive action.

Thank you all very much.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF REVEREND PAUL D. TUNKLE

I appreciate the opportunity to give testimony before this committee. Let me introduce myself, which will explain a great deal about my experience and perspective.

On August 22, 1997, my daughter, Alethea Rose Mary Tunkle, died of a self inflicted gun shot wound to the head. She was 22 years old. The tragedy and trauma of my child's suicide has become one of the defining moments of my life.

Judy and I have been married 32 years. We have three children. Sam is 30, and is a surgery resident in Florida. Elizabeth is 26, and a student in San Francisco. Lea was our middle child. I am an Episcopal priest serving a congregation in Baltimore. Judy is a psychotherapist.

First, some background, then some observations for your consideration. Lea exhibited psychological problems when she was a grade school student. In retrospect, the symptom were of childhood depression. Over a 5 year period, on two separate occasions we engaged in work with a therapist. On each occasion, Lea was identified as the red flag, and we were encouraged to work on our family communications skills. Each time we agreed, but asked the therapist to work with Lea because of her special problems. On both occasions she was not identified as a primary concern. They just missed it, twice.

In her early teens she was compliant and academically excellent. She caused little trouble, and we were content. She was recruited for the biochemical engineering program at Rutgers University, and we were thrilled. We moved to Louisiana as she began her studies at Rutgers in New Jersey. Her progress slowed and her grades began to suffer. I called the dean of her school to inquire about her progress. I was told that since she was an adult, he could not discuss her grades with me. I shared that I was concerned, and he was unable to respond. I told him I would fly up, and that Lea and I would make an appointment to see him. I called Lea and told her I was coming so we could see her dean and visit a psychologist at the university. Between that phone call and my scheduled trip, Lea attempted suicide for the first time. She overdosed on a large quantity of prescription drugs, some of which she stole from her roommates. She left a note which was a clear statement of, "I'm miserable and I want out of here. This is not because you are bad parents. Please forgive me."

The university was unable to help us, even when I had asked for it. Lea was a victim of rape while at college. She found no one who would help her. She held onto her shame and guilt, and it added to her problems. We were unaware of these events until much later.

On her first attempt, she was hospitalized. When she came out of her coma, she was furious as she realized she was still alive. She refused treatment, and we had her involuntarily committed to a psychiatric hospital. Our insurance company funded a 72 hour stay. She was released into our custody while she was still at serious risk for self harm. Our insurance company would not help Lea to get the treatment she needed. Lea was willing to stay, and even requested this. They denied the benefits, and Judy and I had no financial means to enable this to happen on a private pay basis. Lea came home with us for a while, and then returned to school. She worked with a therapist, but did not improve or remain committed. Each time she was tested, she was not diagnosed as clinically depressed, and no meds were prescribed.

Several months later, Lea attempted again. She got a hotel room and assembled the drugs and knives to use. Her college roommate and her sister got wind of her plan and traced her. The police came and agreed not to arrest her if she would voluntarily go to the hospital. She agreed.

At the hospital in New Brunswick, she waited a long time to be seen, was given a cursory exam, and immediately released, while still hallucinating from the drugs she had already ingested. She called us and we arranged to bring her back with us to Louisiana.

She came home and was increasingly erratic in her behavior. She had a violent rage episode and did some physical damaged to our home. She left abruptly, induced her younger sister to leave with her, and flew back to New Brunswick. She was operating on credit cards that were freely offered to her as a college student. Again, she was out of control, and neither our insurance company nor the resources of the university seemed to care.

Finally she came home and slowly declined. We arranged for an outpatient treatment program. Lea was asked to leave the program because she was non compliant. Of course, her illness made her that way, but the program was unable to handle

sick people. In the end, she went out and purchased a handgun and ammunition. Even though she had been hospitalized for psychiatric problems and had two previous suicide attempts, she had no impediment to purchasing a handgun. She ended her life alone and in desperation.

When I consider all that could be done for young people like Lea, I am moved to reconsider her journey. We need well trained counselors available to young people all along their journey. We need teachers who have been trained to identify young people at risk and to work with parents. We need colleges to have resources in place for the shocking number of young people who suffer from depression, anxiety, and who are victims of date rape that goes unreported.

We need not be afraid of the word suicide, nor should we think it is contagious. However, it should be noted that a suicide survivor, namely one who has lost a loved one to suicide, is nine times more likely to die from suicide than the general population. So people like me are an already identified risk group. So are siblings of young people. So are their classmates and friends. They need to talk about their experience, to revisit their trauma, and to feel safe in that sharing. Lea had friends who were and continue to be deeply affected by her death. They are among the many who can benefit from professional help.

I am an ordained minister. In the congregation I served when Lea died, the leaders became so disturbed by her suicide that they asked for my resignation. Their basic statement was that if my child had died from suicide, my credentials to be their ordained leader had been invalidated. The fear and the pain were more than they could stand. They decided running away was better than facing the depth of the tragedy and growing from it. I sought the help of my bishop, who intervened and ruled in my favor. But the lesson is that people with good intentions can make things worse when they lack knowledge and information and training. Judy and I are now training clergy and lay youth leaders in my current diocese on youth suicide prevention skills. Survivors such as us have great credibility among those who are willing to learn.

Lea's death would be even more tragic if we could not use its lessons to help others. We were not bad parents. She did not have bad teachers. Her therapists could have been more knowledgeable and pro active. But there is so much we do not understand. One of the best things we can do now is open the discussion and the dialogue. We can let young people know there are those who will understand and who want to help. We can underscore that they need not travel the path of despair and depression alone. We can help the general population know that suicide is like leukemia. It is a disease that needs compassion and treatment, not shame and guilt.

If Lea could be here, she would say, "Please stop and listen to me. I'm frightened of what is happening to me and I need for someone to know and understand. I don't want to die, but I need to know it won't be like this forever. Can you help me? Can you love me even though I think I want to die? Can you save me from this?"

How I wish we could have heard her and responded better. How I wish she had found those compassionate and understanding voices when she was a little child, when she was a teenager, and when she was a college student. Maybe through your efforts others won't have to die like Lea. We lost not only our daughter, but all the future potential she held for a life filled with blessings and joy. Let's do all that we can to save our children. As our culture becomes increasingly complex and pressured, our children need more help than ever finding their way. Let's be part of that helping system, turning them from the darkness back toward the light of life. Thank you.

RESPONSE TO QUESTIONS OF SENATOR BINGAMAN FROM REVEREND PAUL TUNKLE

Question 1. Access to treatment for mental illness is a serious problem in this country. Yet there is a reluctance to cover mental illnesses at the same level as physical illnesses. How important is health insurance parity between mental and physical illnesses in reducing the risk for suicidal behavior?

Answer 1. My daughter could perhaps have been saved if her first suicide attempt and subsequent hospitalization were covered. We would never think of allowing someone at serious health risk to be released from the hospital after 72 hours. It would be seen as irresponsible and medically unethical. However, the risks and treatment priorities are just as great with mental illness.

Question 2. The New Freedom Commission on Mental Health and the Surgeon General's 1999 Report on Mental Health both identified a national shortage of mental health professionals trained to treat mental illness in children and adolescents. How can we reduce this shortage?

Answer 2. N/A

Question 3. Adolescents with mood disorders, such as major depression and bipolar disorder, are at high risk for suicide. How effective are current treatments for early-onset mood disorders? How can we make evidence-based treatments available to more vulnerable young people?

Answer 3. N/A

Question 4. Substance abuse is also a high-risk factor for suicide. What programs are most effective in reducing adolescent substance abuse?

Answer 4. N/A

Question 5. Teenage suicides are always tragic, but there is a consistently high Native American adolescent suicide rate and a recent dramatic increase in the African American adolescent suicide rate. Do you recommend intense federally supported interventions to address the risk factors that result in these statistics?

Answer 5. N/A

Question 6. Schools serve as gatekeepers for the early identification and referral of young people with mental illness. How can we prepare schools to serve more effectively in this role?

Answer 6. Counselors and teachers would need only modest training to be able to identify risk behavior. Once identified, testing and referrals would be the way to go. Teachers can see things which parents cannot.

Question 7. Over 1,400 school-based health centers deliver primary preventive and early intervention services to more than a million children in 45 States. Mental health counseling is the leading reason for visits by students and the fastest growing component of school-based health care. How can we expand the availability of such services?

Answer 7. Funding and training incentives would enable people to move into these areas. If we are now increasingly aware on the health risks of obesity and inactivity, both of which are easily observable, let's be just as proactive in observing risk behavior in young people's mental health condition, and provide the means to address their need.

RESPONSE TO QUESTIONS OF SENATOR DODD FROM REVEREND PAUL D. TUNKLE

Question 1. Reverend, please let me begin by offering my sympathies on the loss of your daughter. I commend your dedication in testifying today and in your commitment in helping other youth suicide survivors. You mentioned how we cannot be afraid of the word suicide anymore. What recommendations can you make to the subcommittee as to how we can work to eradicate the stigma of fear associated with suicide?

Answer 1. It could help if suicide was an illness that was the subject of study by students in the ordinary course of science and biology classes. The emphasis on illness is analogous to how we have progressed away from the fear factor associated with the word, "cancer." Also, from a linguistic perspective, I use the phrase, "died from suicide" in the same way I would say, "died from leukemia." To say, "committed suicide" implies an association with "committed murder, committed adultery, committed sin." Let's leave those associations behind us.

The best antidote to fear is knowledge and discussion without judgment.

Question 2. Reverend, you mentioned that Lea received little or no medical, psychological or emotional support from her school. What type of support services do you feel should be implemented at colleges and universities across this country?

Answer 2. Colleges need to have the programs for their young people to access. However, many young people experiencing depression will not seek out help. It would be like asking someone having a heart attack to drive themselves to the hospital. Not many can. So I would hope that colleges would have methods to evaluate students based on grades and professor input. Teachers could also have the means to direct their comments and concerns to their dean, who could then in turn refer the matter to the counseling department. Lea would have been helped if her dean had been willing to recognize that her plummeting grades were a sign of a problem, called her in and requested that she work with the counseling services of the school. At the least, he could have asked her what was going on. Ignoring young people when they begin to experience failure can be catastrophic for those young people.

Question 3. Reverend, I applaud the work you and your wife have done in the area of youth suicide postvention. It is rare for us to have a discussion on youth suicide. When we do, it is even rarer to have a discussion on youth suicide postvention. I feel we oftentimes tend to overlook the important needs of families

and friends of children who have taken their own lives. I believe there should some parity between our prevention, early intervention and postvention efforts. With that said, how do you feel we can support suicide postvention services in this country? Do we need more? If so, where? Do we need to make survivors more aware of services that already exist?

Answer 3. The best model for postvention services I know is the Baton Rouge Crisis Intervention Center in Louisiana. Dr. Frank Campbell is the director, and he is an excellent resource. He runs a weekly postvention support group attended by over 50 people. He also has developed the LOSS Team. This group works in conjunction with the Parish Coroner. When a suicide death is reported to the coroner, the LOSS Team is included in the first respondents on the scene, immediately working with the survivors and supporting them in their initial shock. From there they help them find their way to the support systems of the community. The coroner is a critical component in this program's success. Clergy, funeral homes and others can be primary referrals to postvention support services. However, the most important referral source is the primary care family physician. As soon as doctors become aware of the situation, they are best positioned to direct those in need to the community services. The American Association of Suicidology hopes to have a postvention group in every community. Judy and I are part of that network, both in Alexandria, Louisiana, and now in Baltimore. Neither community had these services before we initiated our groups.

Question 4. Reverend, your testimony speaks clearly to the importance of the family in youth suicide prevention and early intervention initiatives. We know that families play a central role, if not the central role, in fostering resilience and self-worth in most of our young people. We also know that children and young adults can often take their lives for reasons that are not easily recognizable to their families. With that said, what tools do you feel families can use to recognize signs of suicide or the emotional and behavioral disorders related to suicide in their children?

Answer 4. Every parent cares deeply about their children's welfare. However, there are some risks that are so fearful to a parent, that denial eclipses their better judgment. Schools can again play an important role here, offering programs and resources for parents to consider. Community education forums would help. In the church I serve, the parish is fully aware of Lea's death, and they access me as a source of help during times of stress and need with their adolescents. If a parent takes a child to the doctor because, "something is wrong," I would hope the physician could direct that family to resources for counseling. The anti-depressant drugs are not enough. Talk therapy is essential to make the holistic kind of impact we seek. If the village takes on suicide as a challenge, I believe the village can make a huge difference for good.

QUESTION OF SENATOR REED FOR REVEREND PAUL TUNKLE

You mentioned your frustration in getting your health insurance company to cover hospitalization costs after your daughter attempted suicide.

Question. What aspects of dealing with health insurance plans are most often cited as barriers to accessing appropriate mental health care?

[Response was not available at print time.]

PREPARED STATEMENT OF CHERYL A. KING

Good morning, Chairman DeWine, and members of the Subcommittee, and thank you for inviting me here today. The number of children and adolescents who commit suicide in our country is alarming, and I applaud you for taking the lead in addressing this tragedy with today's hearing.

I am Dr. Cheryl King, a licensed clinical psychologist and Associate Professor of Psychology at the University of Michigan. I serve as Director of the Child and Adolescent Depression Program at the University of Michigan Depression Center and as Chief Psychologist in the Department of Psychiatry at the University of Michigan Medical School. I am also a Past President of the American Association of Suicidology, a national organization dedicated to understanding and preventing suicide, and serve on the Scientific Advisory Board of the American Foundation for Suicide Prevention. Over the past 15 years, my work has focused on both the clinical and research aspects of youth suicide.

Regrettably, youth suicide is a continuing national tragedy. According to the Centers for Disease Control and Prevention (CDC), suicide is the third leading cause of death among children and adolescents. In 2000, 1,921 young people between the ages of 10 and 19 ended their lives. More teenagers and young adults die from sui-

cide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic disease, *combined*.

A series of highly visible legislative, public policy, advocacy, and organizational events have created a historic juncture for suicide prevention efforts. These were catalyzed in 1999 when *The Surgeon General's Call to Action to Prevent Suicide* stressed the need for effective suicide prevention and intervention strategies.

In 2002, the Institute of Medicine underscored suicide prevention as a significant public health problem with the publication, *Reducing Suicide: A National Imperative*. The report urged the implementation and enhancement of the National Strategy for Suicide Prevention, which lays out a suicide prevention framework for action and guides development of an array of services and programs.

The report of the President's New Freedom Commission on Mental Health released last year stressed the urgent need for action on suicide prevention. The Commission encourages public education efforts to be targeted to distinct and often neglected populations, such as ethnic and racial minorities and adolescents.

METHODS OF SUICIDAL DEATHS

Firearms are the most common method of suicide among adolescents in the United States. In one study, firearms were present in the homes of 74.1 percent of completers and 33.9 percent of suicidal inpatients. Several more recent control studies also demonstrate a strong link between completed suicide and the availability of firearms in the home.

In 1996, firearms were used by 66.4 percent of male suicide victims and by 48.3 percent of female victims (aged 15 to 19). After firearms, the most common methods for adolescent males were hanging (including instances of strangulation and suffocation, 22.7 percent), gas poisoning (3.4 percent), and poisoning that involved solid or liquid substances (2.3 percent). Methods of suicides for female victims included hanging (29.3 percent), solid or liquid poisoning (12.1 percent), jumping from heights (3.1 percent), and gas poisoning (2.5 percent).

SUICIDE RATES ACROSS GENDER AND RACE/ETHNICITY

The suicide rate for youth ages 15 to 19 is 8.2 per 100,000, and the rate for youth between the ages of 10 and 14 is 1.5 per 100,000. The suicide rate for males in the 15- to 19-year age group is markedly higher than that for females. From 1980 to 1997, 83.8 percent of all suicides among this age group were committed by males.

There is a gender difference in completed suicides, although it is the reverse of what is seen with ideation and attempts. Approximately 4 to 10 percent of boys versus 10 to 20 percent of girls report a history of suicide attempt. Thus, two to three times as many girls as boys report having made at least one suicide attempt. At no other time in the human life span is the prevalence of suicide attempts as high as that documented during adolescence.

Suicide rates also differ by racial and ethnic group. American Indian/Alaska Native adolescents are more than twice as likely to commit suicide as any other racial/ethnic group. With 52.9 deaths per 100,000, adolescent American Indian/Alaska Native males are at four times the risk for suicide than are males of any other racial/ethnic group. Among high school students, 10.7 percent of all Hispanics and 14.9 percent of Hispanic females reported attempting suicide in the past 12 months. In addition, 30.3 percent of Hispanic female high school students reported seriously considering suicide, the highest rate of any racial or ethnic group in the country. This compares to 26.1 percent of Caucasian females and 22 percent of African American females.

During 1981 to 1998, the suicide rate for African American youths aged 10 to 19 years increased from 2.9 to 6.1 per 100,000. As of 1995, suicide was the third leading cause of death among blacks aged 15 to 19. However, African American youth have lower suicide rates than Caucasian youth, and African American females have the lowest adolescent suicide rate.

SUICIDAL IDEATION AMONG YOUTH

It is not uncommon for adolescents to think about suicide. The 1999 Youth Risk Behavior Surveillance (YRBS, 2000) found that, in the previous year, 19.3 percent of high school students nationwide had seriously considered attempting suicide, and 14.5 percent had made a specific plan to attempt suicide. Every year, 2 million children and adolescents attempt suicide, and two-thirds of them are females. Among high school students in 1997, 27.1 percent of females seriously considered suicide, compared to 15.1 percent of males.

Suicide ideation includes a broad continuum of suicidal thoughts, ranging from thoughts that others (such as parents) might be better off if the adolescent were

dead to the careful consideration of a specific plan for completing suicide. Such thoughts may be expressed behaviorally, either in writing or in speech. Suicidal actions include the broad domain of self-injurious behavior with some degree of suicidal intent. One of the most striking aspects of adolescent suicidal behavior is the high prevalence rate for non-lethal suicide attempts.

The 1999 Youth Risk Behavior Surveillance data showed that suicidal thoughts tended to peak in the 10th grade. Twenty-two percent of 10th graders had seriously considered suicide in the previous 12 months, and 17.7 percent had made suicide plans.

Although many youth who report suicidal thoughts or attempt suicide do not become suicide victims, these categories overlap substantially. For instance, having frequent thoughts of suicide is the best predictor of suicide attempts, and many youth who attempt suicide report a history of suicidal ideation. Furthermore, greater severity of reported suicidal thoughts increases the likelihood of a suicide attempt within the next year. Approximately 35 to 45 percent of adolescents who complete suicide have a history of suicide attempt.

And while research tools and opportunities currently exist to address the problem of suicide, there continues to be a dramatic mismatch in terms of federal dollars devoted to the understanding and prevention of suicide contrasted with other diseases of less public health impact.

RISK FACTORS FOR SUICIDAL BEHAVIOR

Risk factors for completed suicide and suicidal behavior are similar in most respects. There are a few exceptions, however, such as the more specific relationship between availability of firearms and completed suicide.

Prior Suicide Attempt. A history of prior suicidal behavior is the strongest predictor of future suicidal gestures or self-inflicted harm. While these acts are sometimes thought to be manipulative or attention-seeking, they should not be taken lightly. Youth can be poor judges of lethality, and what is believed to be a gesture may be accompanied by significant suicidal intent. It also may result in substantial physical harm or even suicide because of an error in knowledge or judgment.

Mental Disorder. Approximately 90 percent of youth suicide victims have histories of identifiable mental disorders. The most common types are depressive disorders, alcohol or substance abuse, conduct disorder or patterns of aggressive behavior, and anxiety disorders. Depressive disorders are linked with increased risk for suicide ideation, suicide attempts, and completed suicides. Eighty percent of depressed youth report significant suicidal ideation, and 32 percent of depressed youth report one or more suicide attempts prior to adulthood.

Substance Abuse. Research demonstrates a clear connection between increased severity of suicidal behavior and the presence of alcohol abuse and major depression among adolescent inpatients. Retrospective studies have found that between 25 and 50 percent of adolescent suicides involve the consumption of alcohol, which increases impulsivity, impaired judgment, and mood changes. Research also documents a threefold increase in suicide attempts among depressed youths with comorbid conduct and/or substance use disorders.

Psychosocial Factors. Environmental or family stress, especially a history of neglect or physical, emotional, or sexual abuse, are considered significant risk factors for suicidal behavior. Interpersonal conflict and loss (i.e., break-ups, deaths) also are risk factors. Additionally, hopelessness, impulsivity, aggressive behavior, and agitation are psychological characteristics associated with increased risk for suicidal behavior.

Gay, lesbian, and bisexual adolescents are at increased risk for suicidal behavior. Recent general population surveys indicate that approximately 42 percent of these youth experience suicidal ideation, and 28 percent have made one or more suicide attempts during the past year. Many of the risk factors in these youth are the same as those for heterosexual youth. Problems such as comorbid substance abuse and depression, however, are more common among youth who have a homosexual orientation. In addition, risk factors such as stigmatization and discrimination are specific to those who face negative attitudes within society.

An examination of acculturation issues among immigrants deserves our attention. Research suggests that some acculturating Hispanic adolescents experience high levels of acculturative stress. These adolescents are also at risk for experiencing critical levels of depression and suicidal ideation. In fact, a study revealed that approximately one quarter of the Hispanic American adolescents experienced critical levels of suicidal ideation. The study highlights the importance of assessing and treating the depressed and potentially suicidal acculturating adolescent within a

cultural context. Since the Hispanic culture is not entirely homogenous, further research should examine variables within more specific Latino subgroups.

Contagion. Researchers have found that cluster suicides are more likely to occur among adolescents and young adults than among individuals in other age groups. Approximately 5% of adolescent suicides in the United States are cluster-related. When a youth suicide occurs, intervention aimed at promoting grief and mourning and decreasing guilt, trauma, and social isolation, as well as providing psychoeducation aimed at decreasing identification with the suicidal behavior, are recommended. Media coverage of suicide may spark suicide contagion.

Availability of the Means. The importance of restricting suicidal youth's access to firearms is highlighted by documented associations between more restrictive gun control laws and decreases in suicide rates. Similarly, potentially lethal drugs (such as prescription or over-the-counter sedative drugs) either should be removed from the homes of potentially suicidal youth or monitored closely by parents and guardians.

PATHWAYS TO PREVENTION

Much still needs to be done to prevent youth suicide. Few randomized controlled intervention trials have been conducted with suicidal youth, evaluated interventions have shown limited impact on suicidal ideation and behavior, and suicidal adolescents' adherence with treatment recommendations has generally been poor. We need to develop effective strategies to intervene with youth who have reported thoughts of suicide or who come to our attention following a suicide attempt.

Effective suicide prevention strategies, however, need not be specific to suicide, and, they need not be implemented only in close temporal proximity to imminent suicide risk. A comprehensive, strategic plan for suicide prevention should include multiple points for prevention, maximizing the likelihood of reaching people in need. For instance, preventing the onset of some types of disorders may be feasible. Alcohol and substance abuse is an example of one such risk factor that has been related to a significant portion of suicides across the life span. Furthermore, the early recognition of depressive disorders, with referral for appropriate treatments, may be an effective suicide prevention strategy.

A goal of suicide prevention strategies is to alter developmental trajectories, moving individuals onto healthier pathways fraught with less suicide risk. The less specific and proximal these strategies are, the more likely it is that a successful prevention effort will require the efforts of prevention specialists and advocates in diverse fields. These might include violence prevention (firearm availability), general mental health (access to services), and prevention of hazardous drinking (alcohol/substance abuse education programs). The list of possible collaborators for prevention efforts is lengthy. Many of the prevention strategies that would feasibly result from unified efforts would include societal, public policy, and educational efforts.

"Universal" preventive interventions directed at the entire population, including health promotion and educational efforts, would be examples of efforts to prevent the onset of a risk factor. These might include educational public service announcements, restrictions on advertising for alcoholic beverages, school-based health classes emphasizing mental health and substance abuse problems or health promotion activities. "Selective" interventions, directed at subgroups with some increased level of risk, might include school-based mental health programs for identified "high risk" children. School-based prevention programs are critical in helping children at risk for suicide. Because the school is the community institution that has the primary responsibility for the education and socialization of youth, the school context has the potential to moderate the occurrence of risk behaviors and to identify and secure help for at-risk children.

The Centers for Disease Control and Prevention has demonstrated great commitment to reduce youth suicide rates through an array of initiatives. These include the expansion of a state public health youth suicide prevention program; funding an evaluation of telephone crisis services for adolescents; and funding a program to provide information on the prevalence of Internet use by teenagers in their attempt to seek help for emotional problems.

The National Institute of Mental Health continues to develop and test various interventions to prevent suicide in children and adolescents through early diagnosis and treatment of depression and other mental disorders and is working to find effective methods to evaluate suicidal thinking and behaviors.

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration continues to provide critically needed mental health promotion and youth suicide prevention services primarily through its Children's Mental Health Services Program, Community Mental Health Block Grants, Children's

State Incentive Grants, School-Based Violence Prevention Program, and National Child Traumatic Stress Initiative.

Taking a developmental perspective on the problem of youth suicide, it is evident that we must consider multiple pathways to prevention, place renewed emphasis on prevention strategies that have their impact earlier in the life course or earlier in the course of mental disorder, and collaborate more effectively with colleagues and advocates in other prevention fields. Meeting our suicide prevention objectives will require the unified effort of prevention specialists and advocates in the broader mental health, substance abuse prevention, and health promotion fields.

The development and implementation of an overarching strategic plan for suicide prevention, including a lifespan continuum of accessible prevention options, can be achieved with the shared vision, commitment and resources of disciplines and government working with individuals and communities.

Thank you, again, for the opportunity to present this testimony. I would be pleased to answer any questions.

RESPONSE TO QUESTIONS OF SENATOR DODD FROM CHERYL A. KING

Question 1. Doctor, I commend your dedication and work in the clinical aspects of youth suicide prevention, and I thank you for joining us this morning. In your testimony, you speak to the need for a "comprehensive, strategic plan for suicide prevention that should include multiple points for prevention"—points that include mental health promotion, substance abuse prevention, educational initiatives, law enforcement initiatives, violence prevention, and childhood development. With that said, how can we, as lawmakers, support these plans? What do you feel are the resources that States and localities need to foster them?

Answer 1. There are a variety of ways in which lawmakers could support the development and implementation of youth suicide prevention strategies in States and localities. The bill that you introduced this week to support the planning, implementation, and evaluation of organized activities involving statewide youth suicide early intervention and prevention strategies, bill S. 2175 (108), is a tremendous step forward in this direction. You and the cosponsors, Senators DeWine, Reid, and Smith, are highly commended for this action.

Block grants are another possible mechanism. This strategy could involve block grants administered through the Department of Education (alcohol and drug abuse prevention programs), the Department of Health and Human Services (Maternal and Child Health Bureau, Health Resources Services Administration, Substance Abuse and Mental Health Services Administration), the Department of Justice (Office of Juvenile Justice and Detention Programs); or ideally, through a grant program that requires collaboration between these agencies at the State and community level. Funds could be earmarked for separate youth suicide prevention programs or for the integration of youth suicide prevention strategies into existing programs and services provided through these agencies.

Suicide prevention programs include those that reduce risk factors associated with suicide and those that strengthen protective factors. Furthermore, research suggests that programs designed to reduce youth suicide risk factors (e.g., depression, bipolar disorder, alcohol/substance abuse, physical abuse, sexual abuse, school drop-out, and family history of suicide) are indicated, as are programs designed to strengthen protective factors such as social support, meaningful connections with school and adults, and certain life skills. There are multiple targets in our efforts to reduce the toll of suicide among adolescents.

Several specific recommendations for ways in which lawmakers can support a comprehensive plan for suicide prevention are described below:

(1) A primary recommendation of the President's New Freedom Commission for Mental Health is to implement the National Strategy for Suicide Prevention (NSSP). One of the recommendations included in the NSSP is screening for suicide risk factors in alcohol and other drug abuse treatment centers. Research data consistently and overwhelmingly point to the heightened suicide risk among those with co-occurring alcohol use and mood disorders. Funds could be earmarked for such indicated screening.

(2) Because it has been established that parental psychopathology (depression, substance abuse) and a family history of suicide are associated with suicidal ideation, suicide attempts, and completed suicide in youth, tailored services for parents and families are indicated. Funds administered through MCHB, or separately targeted funds, could provide the resources needed to screen for and intervene in cases of maternal depression and substance abuse. Furthermore, such resources could provide for critical postvention services when a suicide occurs within a family. Other

agencies support child abuse prevention programs and domestic violence prevention programs, which are also associated with suicide risk.

(3) Support of a Senate companion bill to H.R. 3593, introduced by Congressmen Davis of Illinois and Osborne of Nebraska, is highly recommended. This bill proposes to amend the Higher Education Act by providing funding to increase access to mental and behavioral health services on college campuses. This is extremely critical as more students with serious suicide risk factors are attending colleges and universities, and fewer of these students have access to mental health services in the college community. This absence of services is especially tragic during an age span when depression onset is common, hazardous drinking is pervasive, and the suicide rate is known to increase to an even higher level than exists during adolescence.

(4) Incentives are recommended for ecological changes on college campuses to reduce suicide risk among students. Residence hall staff should be trained to recognize signs of risk among students and intervene with appropriate support and referrals to campus services. Academic policies should provide reasonable support to students who need medical leaves for mental illnesses. Campus policies should ensure that parents are involved in the support and care of students with mental illness whenever clinicians judge this could improve the clinical outcome, and that students who demonstrate signs of risk for suicide receive comprehensive clinical evaluations.

(5) The Administrative Branch should appoint an official in one of the Departments (probably DHHS) as coordinator of suicide prevention initiatives across all Departments who have a stake in the outcome. Following *The Surgeon General's Call to Action to Prevent Suicide* in 1999, such a Federal Steering Group on Suicide Prevention was established but it currently has no mandate. It is recommended that such a Federal Steering Group be empowered to coordinate and track federally sponsored suicide prevention activities. In keeping with a recommendation from the National Strategy for Suicide Prevention, the official appointed as coordinator of suicide prevention initiatives should inaugurate a public-private partnership to advance implementation of the National Strategy. This partnership could make funds available for suicide prevention activities, including demonstration projects for new initiatives.

(6) It is recommended that funds be provided to SAMHSA for ongoing support of the National Suicide Prevention Technical Resource Center. This will enable us to assist each State in developing a suicide prevention plan. The Center provides technical assistance and consultation, and can assist States in establishing a "point of coordination" for information about evidence-based suicide prevention services within each region or community. It would also be available to the public-private partnership (mentioned in #5) as a "go to" agency for information, data analyses, and technical assistance.

(7) Health insurance parity between mental and physical illnesses is an essential component of a comprehensive effort to reduce youth suicide. In the State of Michigan, we are currently working on a statewide suicide prevention plan. At planning meetings and open forums attended by school personnel, health department personnel, mental health professionals, and family survivors of suicide, the most commonly raised concern is the absence of resources for many who are suicidal and cannot afford adequate treatment.

Question 2. Doctor, in your testimony you speak of the different suicide rates between gender, race and ethnicity groups. Has there been research conducted that sheds light on why these differences exist? Are there certain social factors at play that might cause children and young adults of a certain gender or ethnicity to be more prone to suicide?

Answer 2. Primary risk factors for suicide among adolescents are mental or psychiatric disorders along with alcohol and substance use or a pattern of hazardous drinking (i.e., binge drinking). The combination of a mood disorder (e.g., major depressive disorder, bipolar disorder) and substance abuse creates a 50-fold increased risk for completed suicide. In fact, research indicates that significant numbers of youth suicides occur under the influence of alcohol. Research also indicates that problems tend to be interrelated among adolescents. Hazardous alcohol use by adolescents is related to suicide as well as to drunk driving, physical fights, violent crimes, risky sexual behavior, and school performance problems. Thus, population groups with higher than average rates of alcohol use and alcohol-related problems (e.g., American Indians, Alaskan Natives; males) can be expected to have higher than average suicide rates. In addition, groups such as American Indians have less access to good health and mental health care.

Youth who are poorly connected or disconnected from major societal support systems (family, school, work) seem to be at high risk for suicide if other suicide risk

factors are also present. This suggests that youth who live in communities with lower rates of social connectedness, higher rates of school drop-out, and high rates of joblessness (e.g., Native American adolescents) may be at increased risk for suicide. For instance, research indicates that suicides often take place after a period of absence from school or after dropping out of high school or not attending college. Although this withdrawal may also relate to a struggle with depression, one study reported that school drop-outs were many times more likely than other young people to attempt suicide, even after adjusting for other diagnostic and social risk factors. Conversely, increased connectedness to major societal support systems is a protective factor against suicide. An excellent example of this is African American females who have particularly low suicide rates relative to other groups nationwide. This low prevalence rate is believed to partially reflect the strong sense of community among African American females, a group whose support system generally includes an extended family of females and involvement in a supportive religious community.

Adolescent girls may be more prone to suicide attempts than adolescent boys due to their elevated rate of depression. There is, however, no gender difference in the prevalence of medically serious attempts, and the prevalence of completed suicide is actually 5–6 times higher in boys than in girls. This much higher rate of completed suicide among boys is thought to be due to both differences in psychopathology and differences in method preferences. In terms of psychopathology, suicide is often associated with aggression, impulsivity, and alcohol abuse. These problems are each more common in males. In terms of method choice, girls tend to favor overdoses. These overdoses tend to be less lethal than the methods commonly used by boys, which include firearms and hanging. They may be less lethal because we have better emergency responses and treatment for overdoses than we have for other potentially lethal means for suicide.

Question 3. Doctor, you mention that there are currently many underfunded research tools and opportunities available to address the problem of youth suicide. If these tools and opportunities were given more support, how could they help us better understand this tragedy? How could they further help our prevention initiatives?

Answer 3. Research is our primary means of developing both (1) a comprehensive understanding of youth suicide, and (2) effective evidence-based suicide prevention strategies that can be feasibly implemented within States and localities.

Government-sponsored surveillance of suicide risk factors and completed suicide among youths and college students is indicated. We hear regularly about our nation's economic indicators, yet have little information available concerning the well-being of our youth. In fact, we know much more about suicide risk factors than we do about the prevalence of these risk factors in our nation's youth and college students. Several specific recommendations can be made in this area.

(1) Repeat the College Health Risk Behavior Survey, which was most recently conducted in 1995 by the Centers for Disease Control.

(2) Enhance the Youth Risk Behavior Survey, which is conducted every 2 years by the Centers for Disease Control. This survey could be improved with additional, more refined questions related to youth suicide risk.

(3) Include measurement of suicide risk factors in federally sponsored longitudinal studies of youth. These studies may have a primary focus on any of a wide range of outcomes (e.g., delinquency, nutritional status, sexually transmitted diseases, homelessness, drug use). Inclusion of suicide-related risk and outcomes would provide substantial information about the course of suicide risk factors, their relations to other indicators of well-being, and developmental pathways to suicide. The importance of learning how protective factors can be strengthened to mitigate the effects of suicide risk factors could be emphasized.

Establishment of suicide prevention research centers is also recommended. Such centers of excellence would enable us to develop more sensitive assessment tools for suicide risk, identify how protective factors can mitigate suicide risk, and develop evidence-based prevention programs and treatments for suicidal youth. They would be a national resource for the rapid dissemination of measurement advances and evidence-based suicide prevention programs. In parallel with this, earmarked research funds are recommended for the efforts of researchers to evaluate statewide strategies and policies, and clinical interventions for suicidal youth. Incentives to conduct research in the area of youth suicide are strongly recommended because of the unique difficulties and challenges inherent in conducting research with a high risk and vulnerable population.

PREPARED STATEMENT OF JOELLE REIZES

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss a critically important public health issue—teen suicide. I am the Director of External Relations for Screening for Mental Health, a nonprofit organization based in Wellesley Hills, MA. I operate a satellite office in Loveland, OH.

Screening for Mental Health's mission is to promote mental health screening as an integral part of overall healthcare. Our teen suicide program is called the SOS High School Suicide Prevention Program. According to the National Center for Health Statistics, suicide is the third leading cause of death for the 15–24 year age group. Indeed, one in eight adolescents between the ages 15–19 will suffer from major depression in any given year.

By way of introduction, I want to pass along a story that was related to me just last month by a school counselor from Cape Cod, Massachusetts. She ran the SOS program in her school last year. As a result, a young man recognized his own symptoms and came to the guidance counselor for help. The guidance counselor contacted his parents, and together, they got him the therapy he needed. A year later, he is doing very well and succeeding in school.

But, 2 weeks ago, this same young man went to class, sat down in his chair, and noticed that the student who had been sitting there before him had written on the desk, "I feel terrible and want to kill myself." Because he had been through the SOS program, this student knew to take this note seriously. He also knew who to go to for help. He alerted the school counselor who was able to work with the teacher's seating charts to identify the student in need. It turns out this young person was actively suicidal. The counselor contacted the parents and got the student into the local hospital to be evaluated that same day. This potentially life-saving intervention resulted from increased awareness achieved through the SOS program.

SOS provides a mental health checkup, via depression screening. It also provides the education teens need to recognize depressive symptoms in themselves or others and the power to act when they see these symptoms. This means that even if a student is not depressed or suicidal at the time of the screening, he or she will know how to recognize the symptoms and what to do to get help if it ever does develop in the future.

The main teaching components of SOS are the depression screening questionnaire and an educational video with discussion guide. The video, entitled Friends for Life, features dramatized vignettes that model the wrong and the right ways to react to a friend exhibiting suicidal signs. The program helps teens to understand the important connection between suicide and undiagnosed, untreated mental illness—which typically involves depression. It strives to increase help-seeking behaviors in teens by teaching them to ACT—Acknowledge, Care and Tell. Acknowledge that what you are seeing are signs of suicide and are serious, C—Tell the person you Care about them and want to help, and T—Tell a trusted adult.

Schools that want to participate in the SOS program register with the Screening for Mental Health office. Screening for Mental Health then sends each school a huge box of materials, which we call a screening kit. This kit contains everything the school needs to implement the program, including procedure and training materials for school personnel, depression screening forms, the Friends for Life video, posters, and a variety of educational brochures—enough materials for 500 students. School health professionals and local clinicians implement the program, creating a team and setting up referral procedures based on local resources.

Most schools learn about the program through one of several professional associations. SOS enjoys the support of the National Association of School Psychologists, the American School Counselors Association, the National Association of Secondary School Principals and many other school-based and mental health organizations. Members of these organizations serve on our Advisory Board and in fact, were instrumental in the development of the program from its very beginning. This is one of the reasons the SOS program is successful—because before we created any materials, we involved these groups and asked them what they wanted in a suicide prevention program. SOS was designed with the input of the very same school nurses, counselors, and school psychologists who actually do the work with the students in the schools every day.

A landmark study conducted by, Dr. Robert Aseltine of the University of Connecticut Health Center, will be released tomorrow, in the American Journal of Public Health. This was a randomized controlled study with 2100 students from five high schools that revealed a 40 percent decrease in suicidal behavior in those exposed to our program. This Nation has an over 20 year history with school-based suicide prevention programs and yet this is the first time anyone has ever seen such a result. This groundbreaking data is part of the reason why the SOS program is the

only suicide prevention program currently listed on SAMHSA's National Registry of Effective Programs.

SOS is also cost-effective. Our current per child cost is only one dollar.

We hope to grow the SOS program with federal support so we can provide the program to as many schools as want it. The program is cost-effective, flexible, easily reproduced in a variety of school settings, and the only program to have evidence of its ability to reduce suicidal behavior. We believe it is an important program option for schools looking to do suicide prevention programming—but most importantly, we believe that our children are worth the investment.

Thank you very much for your time and attention today, and I'd be happy to answer any questions you might have for me.

SCREEENING FOR MENTAL HEALTH,
WELLESLEY HILLS, MA 02481,
March 12, 2004.

Hon. MIKE DEWINE,
Chairman,
Subcommittee on Substance Abuse and Mental Health Services,
Washington, DC 20510.

Hon. EDWARD KENNEDY,
Ranking Member,
Subcommittee on Substance Abuse and Mental Health Services,
Washington, DC 20510.

DEAR MR. CHAIRMAN AND RANKING MEMBER: I am honored to provide the subcommittee with additional information. The responses to the questions posed are reflective of my individual opinions along with the expertise of Douglas G. Jacobs, MD, Executive Director of Screening for Mental Health and Associate Clinical Professor of Psychiatry at Harvard Medical School as well as Robert Aseltine, Ph.D., Associate Professor, Department of Behavioral Sciences and Community Health, University of Connecticut Health Center. Dr. Aseltine is the lead researcher on our recently published evaluation paper in the *American Journal of Public Health*. Dr. Jacobs is the Editor of the "Harvard Medical School Guide to Suicide Assessment and Intervention" and the Chairman of the American Psychiatric Association Workgroup that recently created the APA's first *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*.

I was truly pleased to be able to participate in the hearing on Suicide and Youth and appreciate the subcommittee's interest in this important public health topic. If you require anything else, please do not hesitate to contact me.

SINCERELY,
Joelle M. Reizes,
Director,
External Relations Screening for Mental Health.

RESPONSE TO QUESTIONS OF SENATOR DODD FROM JOELLE REIZES

Question 1. Thank you very much for joining us this morning. In your testimony, you say that the main teaching components of the SOS Program are a depression screening questionnaire, an educational video, and a discussion guide. How are these materials conceptualized? How do they interact with one another?

Answer 1. The program is designed to provide a mental health check-up (paper and pencil screening form) for every student as well as an educational program that informs students about the symptoms of depression and suicide, their relationship, and the importance of treatment (video and discussion guide). Thus, students can assess their own symptoms at the time of the program, but are also empowered to identify the symptoms of depression and suicidality in themselves and a friend whenever they occur and know how to access help. As you may know, depression is an episodic event. This means that a student may not have depression at the time of the screening but may develop it 6 months later. Thus, screening alone is not the answer. Education must be a part of the program so that students will know what to do, how to identify depression and suicide and how to access help if the symptoms develop in themselves or a friend later.

The two-part program is usually implemented during one classroom period by existing school personnel. Most schools provide the program to all students the first year, and then simply to the next incoming class (e.g. 7th, 8th or 9th graders and transfer students).

SOS also provides educational material for students as well as for school staff, and parents. There is a version of the screening form that can be sent home to parents so that they can "take" the screening for their children. It helps parents assess their child's attitudes and behaviors, and identify possible depression or suicidality. The most important aspect of the parental screening form may be that it helps parents open up a dialogue about these issues with their children.

Question 2. I was pleased to hear that the University of Connecticut School of Medicine conducted an evaluation of the SOS Program. I was also pleased to learn that the Hartford Public Schools—an urban school system in my State with a great need for adequate mental health services—participated in the evaluation. When designing the SOS Program, how do you develop the materials so that they can reach children and young adults from all different geographic, racial, ethnic, and socioeconomic backgrounds?

Answer 2. We developed the materials with the hope that they would be user friendly to teens from diverse backgrounds by utilizing the expertise of school-based professionals on our Advisory Board. The vignettes address different issues that relate to a variety of people from different backgrounds and the people in the videos discussing their individual experiences with suicide and depression come from a variety of racial backgrounds. The program has been used and is well-received by schools in urban, suburban and rural communities.

Based on the results of our evaluation to date, we are confident that our program addresses the needs of children from disadvantaged minority backgrounds as well as middle-class white teens. Our preliminary work from last year where we expanded this program into suburban areas, suggests that this program is equally effective in urban and suburban areas. The suicide reduction we saw in the evaluation study was independent of race. Please note that the SOS program provides Spanish language materials as well as English language materials.

Clarification: Officially, Dr. Aseltine's affiliation is not with the School of Medicine. The University of Connecticut Health Center holds the School of Medicine and School of Dental Medicine. The Department of Behavioral Sciences and Community Health, with which Dr. Aseltine is affiliated, is within the Dental School due to long-standing historical reasons. However, Dr. Aseltine's specialty is in depression and mental health.

RESPONSES TO QUESTIONS OF SENATOR REED FROM JOELLE REIZES

Question. The New Freedom Commission on Mental Health and the Surgeon General's 1999 report on Mental Health both identified a national shortage of mental health professionals trained to treat mental illness among our youth. Would you agree that the shortage of professionals in your community is a barrier to treatment? What has been the experience in your community?

Answer. The shortage of trained mental health professionals is an important national issue. Of particular import to teen suicide prevention is the shortage of child and adolescent psychiatrists. Many communities that would like to conduct suicide prevention and other mental health campaigns such as the SOS program or National Depression Screening Day hesitate to do so because they do not know who will treat the individuals identified by a screening. We refer the subcommittee to the American Academy of Child and Adolescent Psychiatry's document "AACAP Work Force Data Sheet" available at http://www.aacap.org/training/workforce.htm for a summary of this critical public health issue. While we recognize that this shortage can be a barrier to treatment, a shortage of providers does not reduce the need for screening or treatment. Rather, it calls for increased training of mental health professionals in this important area.

Most schools that use the SOS program feel that, even in the face of clinician shortages, it is still important to identify young people at risk for depression and suicide and work with the students and their families. The school professionals can triage those who need emergency services while providing alternate counseling to those who have been reached at an early enough stage until resources are available.

We feel that it is important for all mental health professionals to be adequately trained in suicide assessment and intervention, with information that is most current and based on the best possible science and clinical training. The American Psychiatric Association recently published a *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*. The guideline is intended to help reduce individual patient's suicide risk by giving psychiatrists tools to assess for risk and formulate treatment strategies. The new guideline provides recommendations for assessment and treatment interventions based on evidence from research literature and clinical consensus. It should be noted that this guideline is designed pri-

marily to address practices as they pertain to adult patients, ages 18 and over, and are appropriate for our discussions around college mental health practices rather than adolescent. There are practice parameters for patients under 18, developed by the American Academy of Child and Adolescent Psychiatry, www.aacap.org.

The development process for the new American Psychiatric Association guideline required more than 2 years and included review of over 34,000 articles from the scientific literature published since the 1960s. With oversight from APA's Steering Committee on Practice Guidelines, early drafts of the guideline were reviewed by more than 100 experts and APA members, eight professional organizations, and numerous APA components. A final draft was reviewed and approved by the APA Assembly and Board of Trustees. The guideline has been published as a supplement to the November issue of the American Journal of Psychiatry and is available on the APA website at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

Screening for Mental Health is currently working to distribute this guideline to psychiatric residents across the Nation. It is intended by the APA that this guideline will help provide needed training to mental health professionals in the treatment of suicidal patients and thereby help reduce the barriers to treatment.

RESPONSE TO QUESTIONS OF SENATOR BINGAMAN FROM JOELLE REIZES

Question 1. Access to treatment for mental illness is a serious problem in this country. Yet there is a reluctance to cover mental illnesses at the same level as physical illnesses. How important is health insurance parity between mental and physical illnesses in reducing the risk for suicidal behavior?

Answer 1. Mental health parity is needed, quite simply, because mental illnesses should be treated equally as other illnesses. There is no other situation in which we would discriminate against a person because they have an illness that involves one body part or organ, rather than another. And yet, by not offering parity, we routinely do this to patients with mental disease. The reduction of suicidal behavior turns on early identification and adequate treatment. Adequate treatment is predicated on the idea of access to mental health care, for which parity is a necessary precursor. This is an especially critical issue for the 16–17 percent of Americans under age 65 without health insurance, as well as for the underinsured. In 2002 16.7 percent of American children were living in poverty, with rates of over 50 percent for Hispanic and African American children. In 2001 11 percent of children had no health insurance and Hispanic and Native American children are even less likely to have health insurance than their peers. Access to mental health services is further compromised for these populations by a lack of parity in health insurance and coverage for mental illness. [All stats from U.S. Department of Health & Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics]

Question 2. The New Freedom Commission on Mental Health and the Surgeon General's 1999 Report on Mental Health both identified a national shortage of mental health professionals trained to treat mental illness in children and adolescents. How can we reduce this shortage?

Answer 2. We defer to our colleagues at the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association on this issue. We refer the subcommittee to the American Academy of Child and Adolescent Psychiatry's document "AACAP Work Force Data Sheet" available at http://www.aacap.org/trig/workforce.htm for a summary of this topic. As noted in the response to Senator Reed, the shortage of trained professionals does not reduce the need for screening mechanisms or treatment. We believe the answer lies in continuing outreach and education efforts to professionals and the public to both help train professionals and identify those in need of help.

Question 3. Adolescents with mood disorders, such as major depression and bipolar disorder, are at high risk for suicide. How effective are current treatments for early-onset mood disorders? How can we make evidence-based treatments available to more vulnerable young people?

Answer 3. As we know, the efficacy of pharmaceutical treatments is under investigation now. We hope that the broad examination will shed light on this subject and that the benefits and risks will be weighed appropriately. In addition, a substantial body of literature supports the efficacy of psychotherapy in the treatment of specific disorders that carry with them an increased risk for suicide, especially non-psychotic major depressive disorders. Specifically, interpersonal therapy and cognitive behavioral therapy have been found effective in clinical trials of adults with major depression.

There is no single answer to preventing suicide; therefore, evidence-based prevention activities and treatments must be seen as part of an overall continuum of identification and care. Congress can urge schools, colleges, and communities to view suicide prevention as an important public health issue and encourage, through funding channels, the further training of mental health clinicians, adequate mental health treatment resources such as in-patient care, partial day hospitalization, outpatient counseling, pharmacy benefits and mental health parity.

Also, comprehensive, systematic screening services must be an integral component of any suicide prevention initiative. Screening leads to early identification of the most common risk factor for suicide—mental illness. Research clearly shows that the earlier we identify a disorder, the better the chance we have of positive outcomes.

Question 4. Substance abuse is also a high-risk factor for suicide. What programs are most effective in reducing adolescent substance abuse?

Answer 4. We cannot comment on the efficacy of adolescent substance abuse programs. However, the strength of the association between alcohol and suicide in the SOS research data is startling: those reporting that they have used alcohol when feeling down are almost 6 times more likely to report a suicide attempt during the past year and over 4 times more likely to report a lifetime attempt than are those who have not used alcohol when feeling down. Similarly, those reporting an episode of bingeing in the past 12 months are almost 3 times more likely to have attempted suicide in the past year and 4.5 times more likely to have ever attempted suicide than those who have not had an episode of binge drinking.

Question 5. Teenage suicides are always tragic, but there is a consistently high Native American adolescent suicide rate and a recent dramatic increase in the African American adolescent suicide rate. Do you recommend intense federally supported interventions to address the risk factors that result in these statistics?

Answer 5. Additional research is needed to identify the risk factors that are unique to these populations. Racial and ethnic differences in culture, religious beliefs and societal position may influence not only rates of suicide but also beliefs about and views on death and suicide. It is important to develop interventions that are culturally sensitive and that address issues that may be specific to certain ethnic minority populations including African American and Native American teens.

Question 6. Schools serve as gatekeepers for the early identification and referral of young people with mental illness. How can we prepare schools to serve more effectively in this role?

Answer 6. We need to provide schools with the tools they need to do the job of early identification and referral. The SOS program serves this very need. It has been recognized by school professional organizations as the program of choice, including the National Association of School Psychologists, National Association of Secondary School Principals, American Counseling Association, American Academy of Nurse Practitioners, American School Counselors Association, and the National Association of Social Workers, among others.

The SOS materials serve to educate faculty and staff and parents, as well as students. By providing schools with a training manual and video for staff, the screening and educational materials and videos for students, and parent resources we provide schools with everything they need to implement the program. We hope to gain Federal support for SOS so that we can provide the program to any school that wants it.

Question 7. Over 1400 school-based health centers deliver primary preventive and early intervention services to more than a million children in 45 States. Mental health counseling is the leading reason for visits by students and the fastest growing component of school-based health care. How can we expand the availability of such services?

Answer 7. As you and your colleagues have aptly noted there is a shortage of professionals trained specifically in child and adolescent mental health. In order to expand the availability of such services we must expand the base of professionals who are qualified to treat suicidal teens. Here again we defer to colleagues at the American Academy of Child and Adolescent Psychiatry. In general, however, school-based health centers can be an important resource in meeting mental health needs, both by identifying those in need and referring out for specialized treatment, especially in hard to reach populations and for the under and uninsured. Expanding such clinics will require both funding and training efforts.

PREPARED STATEMENT OF LAURIE FLYNN

Good Morning Mr. Chairman and Members of the Subcommittee; as Director of the Carmel Hill Center for Early Diagnosis and Treatment within the Division of Child and Adolescent Psychiatry at Columbia University, I am honored to participate as a witness at today's hearing on youth suicide prevention. The Carmel Hill Center administers the Columbia University TeenScreen® Program, a mental health screening and suicide prevention initiative for youth.

The issue of youth suicide prevention is personal to me; my daughter made a suicide attempt during her senior year of high school. She had deteriorated inexplicably and rapidly, moving quickly from severe stress to depression with few warning signs. At the time, there was no reliable way for youth to be screened for mental illness or suicidal tendencies and parents had no reliable way of knowing their child was in danger. Thankfully my daughter was successfully treated and went on to college and graduate school. Last year she was married. My family's story has a happy ending, but thousands of parents and teens are not so fortunate.

THE EVIDENCE BASE FOR MENTAL HEALTH SCREENING AS A MEANS OF YOUTH SUICIDE PREVENTION

Since my daughter was first treated for mental illness, evidence-based youth mental health screening programs have been researched, developed, proven to work, and made available for use. These suicide prevention initiatives, which include not only the Columbia University TeenScreen Program but also other programs such as the Signs of Suicide Program developed by our colleagues at Screening for Mental Health, Inc., have undoubtedly helped improve, if not saved, the lives of thousands of teens. Had the TeenScreen Program been available in my daughter's high school, I most likely would have had a year or more warning that she needed help.

There exists a growing body of scientific research that has found screening to be an effective way to find those who are suffering from mental health problems and are at risk for suicide. Screening provides a way to find these youth before their lives have been permanently derailed by related poor academic achievement, substance use, self injury and suicide attempt. Screening is especially important because many conditions, especially adolescent depression, do not always exhibit easily identifiable symptoms. Universal screening, when linked with referral to appropriate services, can significantly reduce the devastating impact of mental health problems on young lives.

The move to offer mental health screening to every teen in the United States is based on the findings of a psychological autopsy study published in 1996 by Dr. David Shaffer, Chairman of the Department of Child and Adolescent Psychiatry at Columbia University. The study provided information about teenagers who commit suicide and how suicides could be prevented, revealing that teen suicide is not the unpredictable event we had once thought it to be. In fact, teens that commit suicide suffer from a very specific range of mental illnesses. Dr. Shaffer found that 91 percent of the teens that committed suicide had a psychiatric disorder at the time of their deaths. This finding has now been replicated in several national and international studies. In Dr. Shaffer's study, the majority of boys who committed suicide suffered from depression, abused alcohol or drugs, and/or had made a prior suicide attempt. Most girls who committed suicide either suffered from depression or had made a prior suicide attempt (Shaffer et al., 1996a).

The original study of the TeenScreen Program on 2,004 high school students revealed the program's unique ability to uncover youth at risk for suicide, but unknown to have problems and not receiving professional help for them (Shaffer et al, 1996b). Only 31 percent of those with major depression, 26 percent of those with recent suicide ideation, and 50 percent of those who had made a past suicide attempt were known by school personnel to have significant problems and receiving help. This indicates that the majority of students who are suffering from a mental illness and are at risk for suicide are currently not detected.

Dr. Shaffer hypothesized that if youth were screened for these disorders and those found to be at risk were treated, most suicides could be prevented. As a result of Dr. Shaffer's research, the Columbia University TeenScreen Program was developed.

THE COLUMBIA UNIVERSITY TEENSCREEN® PROGRAM

The TeenScreen Program has a simple purpose: to screen youth for mental illness and suicide, identify those who are at risk, and link them to appropriate treatment. In 1999, we were able to take the available research and apply it in the real world with the launch of the national TeenScreen Program. As part of our initiative to en-

sure that every teenager receives a mental health screening before leaving high school, we have trained 108 screening sites in 34 states, Guam, Canada and Panama. We currently have over 200 sites in development. In 2003, we were able to screen approximately 14,200 teens at these sites; among those students, we were able to identify approximately 3,500 youth with mental health problems and link them with treatment. This year, we believe we will be able to identify close to 10,000 teens in need, a 300 percent increase over last year.

The TeenScreen Program works by creating partnerships with communities across the nation to implement early identification programs for suicide and mental illness in youth. We work with communities to develop screening programs that are based on the TeenScreen Program, yet adaptable to accommodate the specific needs and resources of each community. Most screening programs take place in schools, but the program can also be implemented in residential treatment facilities, foster care settings, clinics, shelters, drop-in centers and other settings that serve youth.

Once a screening partner has been identified, we ask that the potential screening site complete some basic requirements. The site must submit a plan for screening youth and agree to identify a site coordinator, agree to screen a minimum of 200 youth per year, commit to routinizing screening in their community, and provide biannual reporting of screening results. We do not require data collection for research purposes, and we work with potential sites through the application process to help them fulfill each requirement to the best of their ability. In fact, many of our current sites began screening as part of a 1-year pilot and, once they felt comfortable with the process and obtained further community resources and support, have since advanced to screening routinization.

It is important to note that we require both parental consent and participant assent before a youth can take part in the screening process, thus making screening a completely voluntary activity.

In the first stage of the actual screening process, all youth who consent to screening and obtain parental consent complete the Diagnostic Predictive Scales (DPS). The DPS is a 10-minute self-administered questionnaire that screens for social phobia, panic disorder, generalized anxiety disorder, major depression, alcohol and drug abuse, and suicidality.

Youth who report no mental health problems on the DPS are dismissed from the screening, and youth who require further attention are advanced to the second stage where they are assessed by a mental health clinician to determine if further evaluation or treatment would be beneficial. If professional services are recommended, the youth and his or her family are assisted with the referral process.

At a time of budget shortfalls at both the federal and state levels, I am aware that the subcommittee is particularly interested in the costs associated with our screening program. I am happy to report that as part of our new campaign to ensure that every teenager receives a mental health check-up before leaving high school, we are offering 400 communities across the nation free individually tailored screening projects, including free screening instruments, materials, and software; free pretraining consultation; free training; and free post-training technical assistance.

Most sites incur a minimal cost for implementing a screening program. The primary cost associated with screening is staff; other costs include computers and supplies. Many schools and communities can implement their programs at no additional cost by utilizing resources that are already in place (e.g., the school social worker conducts the screening and uses the school's computer lab to do so) or by securing volunteers and interns to staff the program. Schools that do not have these resources in place have been able to find grants to support the screening staff, which can be as small as one person, and supply needs. Because the program is flexible and can be implemented in a variety of ways, it is able to fit into any budget.

STATE EFFORTS

Through our outreach efforts and community partnerships, we have been enormously pleased to work with several states that have taken the initiative to implement statewide youth mental health screening and suicide prevention strategies. Among these states are Ohio, Florida, Nevada, and New Mexico; in addition, recent activity in Pennsylvania and Iowa have put those states on the path to a statewide strategy.

For example, in the Chairman's home state of Ohio, we have been fortunate to work with Mike Hogan, PhD, Director of the Ohio Department of Mental Health, Chair of the President's New Freedom Mental Health Commission, and a member of our National Advisory Council. In February 2002, Commissioner Hogan initiated a statewide TeenScreen effort by soliciting five county mental health boards to be part of a pilot program. Over the next 10 to 18 months, the development of these

screening sites was supported by staff at the TeenScreen Program as well as through a grant of $15,000 from the Department of Mental Health to each mental health board who is participating in the pilot program (Cuyahoga County, Clermont County, Butler County, Stark County, and Wayne/Holmes Counties).

In Senator Ensign's home state, the Nevada Department of Education recently announced plans to create a new office within the department, the Center for Health and Learning. Our partnership with Nevada began 2 years ago in the Clark County Health District, which maintains 3 school-based health centers serving ten schools in Las Vegas and North Las Vegas. During this time, health district staff has used the TeenScreen Program in 3 of the area schools. Due to the success of the program in Clark County, and through the continuous outreach and collaborative efforts of the county's health district staff, the Nevada Department of Education has taken an interest in the TeenScreen Program, resulting in the creation of the Center for Health and Learning. The development of the Center has been led by Gary Waters, State School Board President, and strong supporter of the TeenScreen Program. The Center will, among other activities, be responsible for setting up a statewide program to oversee the TeenScreen Program in interested schools and districts. The Center's oversight will include the development, start-up, and implementation of TeenScreen sites as well as ongoing support, including planning support, coordination of provider services, and quality assurance guidance, for these new sites.

In New Mexico, home to Senator Bingaman, a collaborative relationship with the New Mexico Department of Health's Office of School Health and the University of New Mexico's Department of Psychiatry has led to successes on many fronts. Our partnership in the state began two and a half years ago with a TeenScreen Program pilot in 5 school-based health centers (including Silver City SBHC, Ruidoso SBHC, Acoma-Laguna SBHC, and Bernalillo SBHC). This pilot has led to the stationing of a TeenScreen Program Western Regional Coordinator in Albuquerque, integration of the TeenScreen Program into several Robert Wood Johnson funded research grants, and the adoption of screening by several frontier schools, including Newcomb, Clovis, and Lovington. Youth mental health screening is also at the forefront of issues to be included in New Mexico's behavioral health restructuring plan, and have a great deal of support across state agencies. As the Senator is aware, recent suicides in Pojoaque schools have prompted that community and others to seek out solutions that better address the unique challenges that New Mexico communities face, and the TeenScreen Program is one of the approaches being considered.

In Iowa, home to a member of the full committee, Senator Harkin, a tragedy occurred just this past October. A student at Lincoln High School in Des Moines committed suicide, and subsequently parents and school officials became suspicious of a suicide pact. In response to the suicide and the suspected suicide pact, and with the help of former Governor Terry Branstad, a member of our National Advisory Council, TeenScreen Program staff offered our assistance and our program to Lincoln High School and the Des Moines school district. This incident coincided with a groundswell of interest in screening from school social workers, most of who had heard about TeenScreen at a conference, and in the State Department of Education. Ultimately, we were able to convene two important meetings; the first was with representatives of the State Department of Education and school social workers from around the state; the second was with the principal of Lincoln High School, members of the school board, and representatives of the Des Moines School District, among other attendees. As a result of these two meetings, we are on our way to implementing youth mental health check-ups not only in the Des Moines School District, but across the state as part of a statewide TeenScreen Program pilot.

In Florida, our partnership is an example of the relationship between youth suicide, mental illness, and substance abuse prevention. TeenScreen Program staff has been working with Governor Jeb Bush to help achieve his goal of reducing suicides in the state. We have specifically collaborated with Jim McDonough, Director of the Office of Drug Control and the state Suicide Prevention Talk Force. In partnership with the University of South Florida we are piloting district wide mental health screening of 9th graders in Hillsborough and Pinellas counties. Staff has met with mental health professionals and community leaders, elected officials, advocates, the business community, and family organizations to build a base of support for media outreach and awareness.

THE CASE FOR EXPANDED MENTAL HEALTH SCREENING

Research has established that evidence-based screening programs are one of the most effective means of youth suicide prevention. Research has also shown that one of the best times to catch youth at risk of suicide is in high school, with suicide rates among teens rising dramatically around age 14 to 15. While we are proud to have

trained 108 screening sites in the use of the TeenScreen Program, only a fraction of our nation's secondary schools currently offer students a mental health screening.

The need for increased availability of youth mental health screening is evidenced by the fact that close to 750,000 teens are depressed at any one time, and an estimated 7–12 million youth suffer from mental illness. While treatments are available for these severely disabling disorders, sadly, most children do not receive the treatment they need. Among teens that are depressed, 60-80 percent go untreated. Among all teens with mental illness, two out of three do not receive treatment.

It has been established that the failure to adequately care for the mental health of our youth is connected to youth suicide. Suicide continues to be the third leading cause of death among our youth. In fact, more adolescents die by suicide as die from all natural causes combined. This does not even take into consideration the 19 percent of teens who contemplated suicide, the 9 percent who made a suicide attempt, and the 3 percent who made an attempt requiring medical attention, as identified by the CDC in 2001.

The good news is that in the past year, there has been a wave of support for youth mental health screening, led by the final report of the President's New Freedom Commission on Mental Health. One of only 6 reported goals of the commission is that "Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice." The commission found that among children such screening, assessments, and referrals "can prevent mental health problems from worsening." The commission's final report also states that "schools are in a key position to identify mental health problems early and to provide a link to appropriate services."

I am especially pleased to report that the commission named the Columbia University TeenScreen Program a model program for early intervention.

NATIONAL SUPPORT FOR MENTAL HEALTH SCREENING

In addition to the endorsement by the President's New Freedom Commission on Mental Health, to date, 21 national mental health, education, and other organizations have endorsed the goal of offering every American teen receives a mental health check-up before high school graduation. A list of these organizations has been provided for committee members.

We have also found success in Congress and among state legislators. Language in fiscal year 2004 omnibus appropriations bill calls on the Federal Government to report on what it is doing to encourage mental health check-ups for youth, including school based screening. We see this as a first step towards identifying one or more federal funding streams in the Department of Health and Human Services and the Department of Education to support screening.

Last September, Congresswoman Rosa DeLauro introduced the Children's Mental Health Screening and Prevention Act, H.R. 3063, bipartisan legislation to fund a federal demonstration program encouraging diverse sites to implement and evaluate youth mental health screening. The legislation, which currently has 37 cosponsors in the House but no companion legislation in the Senate, would authorize up to $7.5 million a year to enable up to 10 interested communities to participate. At the state level, the Pennsylvania, Georgia, and Illinois state legislators have introduced resolution specifically encouraging the use of mental health screening as a means of identifying youth at risk for suicide. In Pennsylvania, this resolution was followed-up by a joint hearing on youth suicide prevention at which we were honored to testify.

CHALLENGES FOR THE SUBCOMMITTEE

The challenge to the subcommittee is clear. There now is a proven way to find young people before they make an attempt on their lives. Families are counting on your leadership.

Fortunately, the subcommittee, the committee, the Senate, the Congress, and the entire federal government are in a position to ensure that every teen in America is offered a mental health screening as a means of suicide prevention. More leadership is needed, not necessarily more money. Our experience shows that the government can support youth mental health screening by redirecting existing resources. For example, state and local education agencies can use Safe and Drug Free Schools and Communities dollars to support school-based mental health services and suicide prevention activities. Both the federal and state governments must do a better job of encouraging local school districts to include mental health check-ups in their grant applications.

Looking back at the example set by Nevada, I would encourage the Federal Government to support the appointment of a state leader on suicide prevention. Currently, suicide prevention activities are administered by a myriad of state agencies

and councils, sometimes in coordination with mental health services, sometimes in coordination with health services such as injury and violence prevention, and sometimes in coordination with education services. This leader can be a person currently working on youth suicide prevention at the state level, but who would now be responsible for coordinating and disseminating available information on youth suicide prevention and youth mental health screening.

Finally, Congress will soon consider reauthorization of the Substance Abuse and Mental Health Services Administration. I know the subcommittee joins me in thanking the agency for their leadership on the issue of youth suicide prevention. I encourage Congress to ensure that the agency has the resources it needs to continue its work and to increase its support of youth mental health screening.

I am grateful for the subcommittee's leadership on and support for youth suicide prevention and am ready to work with you to ensure that all children are on the path to lead happy and healthy lives.

I would be more than happy to take any questions from the subcommittee members.

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SOS HIGH SCHOOL SUICIDE PREVENTION PROGRAM

A PROGRAM OF SCREENING FOR MENTAL HEALTH

Sponsors

American Academy of Child and Adolescent Psychiatry

American Academy of Nurse Practitioners

American Association for Marriage and Family Therapy

American Counseling Association

American School Counselor Association

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National Association of School Nurses

National Association of School Psychologists

National Association of Secondary School Principals

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School Social Work Association of America

Screening for Mental Health

Douglas G. Jacobs, MD
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www.mentalhealthscreening.org

EMBARGOED UNTIL March 3, 4pm Contact: Joelle Reizes, 513-683-1599

HIGH SCHOOL SUICIDE PREVENTION PROGRAM REDUCES SUICIDE ATTEMPTS BY FORTY PERCENT;
SOS Program First to Show Reduction in Suicidal Behavior

The *SOS High School Suicide Prevention Program* reduced suicide attempts by 40% in high school students exposed to the program, according to a paper in today's *American Journal of Public Health*. The SOS program is the first school-based suicide prevention program to show a reduction in suicidal behavior in a randomized controlled study. SOS is a program of the non-profit organization, Screening for Mental Health, Inc.

"What makes this program unique is that it is the first time in twenty years of research on school-based suicide prevention programs that we have seen this type of effect on suicidal behavior," says study lead author Robert Aseltine, Ph.D. of the University of Connecticut Health Center.

Dr. Aseltine, along with co-author Robert DeMartino, MD, of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, studied five high schools in Hartford, CT and Columbus, GA with a total of 2100 students. The students were randomly assigned to intervention and control groups. Self-administered questionnaires were completed by students in both groups approximately three months after program implementation.

Researchers observed significantly lower rates of suicide attempts as well as greater knowledge and more adaptive attitudes about depression and suicide in the intervention group.

"Our analysis suggests that a substantial portion of the effect of the SOS program on self-reported suicide attempts may be explained by improving the subjects' understanding and attitudes about depression and suicide," says Dr. Aseltine.

The SOS program was also recently designated as a "promising program" by the Substance Abuse and Mental Health Services Administration (SAMHSA), becoming the only suicide prevention program selected for its National Registry of Effective Programs (NREP).

The SOS program was developed with assistance from, and is endorsed by, leading school-based professionals' organizations including the National Association of School Psychologists, American School Counselor Association, National Association of School Nurses, National Association of Secondary School Principals, among others.

Susan Gorin, CAE, National Association of School Psychologists Executive Director says, "NASP endorses the SOS program because it works. Our members see it working and the research backs that up. Schools across the nation should take notice. Saving a student's life could take as little as one class period."

-more-

One unique feature of the SOS program is that it combines two suicide prevention strategies into one program by combining depression screening with an educational program about suicide and mental illness.

Dr. David Satcher, former U.S. Surgeon General, highlighted the SOS program when he rolled out the National Strategy to Prevent Suicide in May, 2001.

The program is designed to be easily replicable in a variety of school settings, using existing school personnel. Typically, it is implemented during one or two classroom periods. The program teaches high school students to respond to the signs of suicide as a mental health emergency, much as one would react to a heart attack as a health emergency. It teaches youths how to recognize the signs of suicide and depression in themselves and others and the specific action steps needed to respond to those signs. The goal is to make the action step -- ACT -- as instinctual a response as the Heimlich maneuver and as familiar an acronym as "CPR." ACT stands for Acknowledge, Care, and Tell. First, ACKNOWLEDGE the signs of suicide that others display and take them seriously. Next, let that person know you CARE about him or her and that you want to help. Then, TELL a responsible adult.

Screening for Mental Health, the nonprofit group that created the SOS program, is well known in the mental health field for its landmark program, National Depression Screening Day® and felt it could adapt some of the techniques used in the community-based program to provide an evidence-based, cost effective turn-key program for schools.

SMH's Executive Director and founder, Douglas G. Jacobs, MD, is a nationally renowned suicidologist and has had a long interest in working to prevent suicide.

"The SOS program gives young people a 'mental health check-up' as well as the knowledge to recognize depression when it occurs in themselves or a friend at any time in their lives," says Jacobs, an Associate Clinical Professor of Psychiatry at Harvard Medical School. "It is important to convince our youth that suicide is a tragic, permanent solution to a temporary condition. That condition is usually depression or a related disorder, which is treatable."

Since 2000, the program has been implemented in more than 1300 schools across the country. The cost to schools is less than 40 cents per student.

Screening for Mental Health is based in Wellesley Hills, MA. For more information contact, 781-239-0071 or www.mentalhealthscreening.org.

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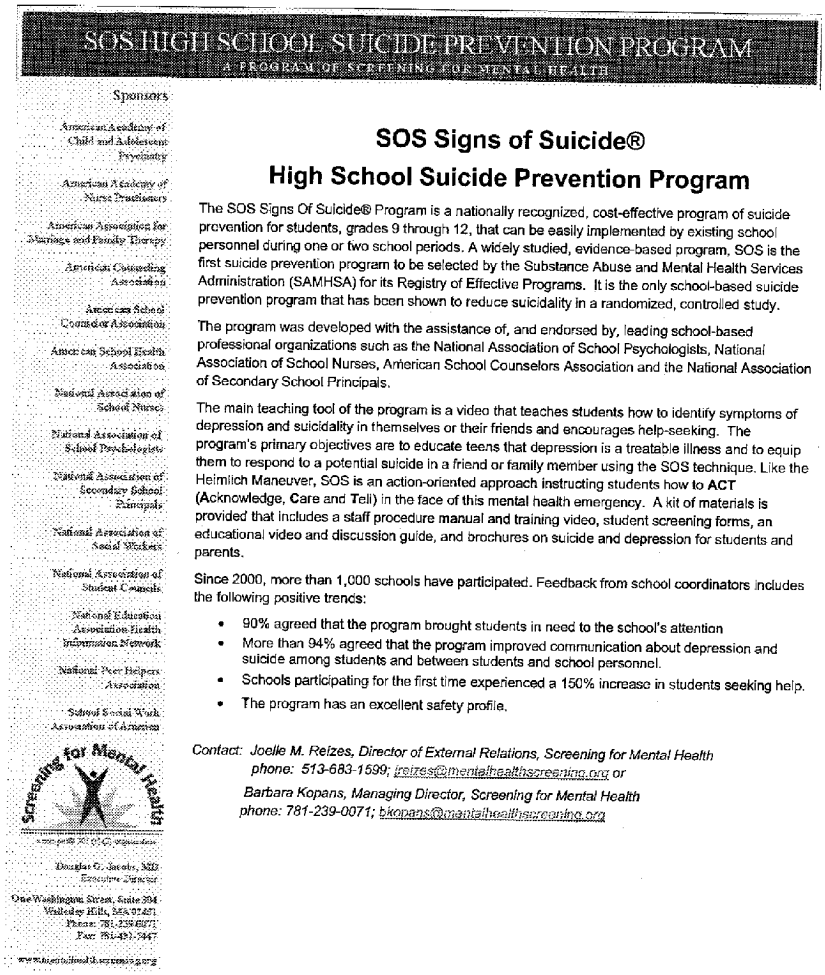

SOS HIGH SCHOOL SUICIDE PREVENTION PROGRAM

A PROGRAM OF SCREENING FOR MENTAL HEALTH

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American Academy of Child and Adolescent Psychiatry

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Screening for Mental Health

A non-profit 501 (c) (3) organization

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SOS Signs of Suicide®

High School Suicide Prevention Program

The SOS Signs Of Suicide® Program is a nationally recognized, cost-effective program of suicide prevention for students, grades 9 through 12, that can be easily implemented by existing school personnel during one or two school periods. A widely studied, evidence-based program, SOS is the first suicide prevention program to be selected by the Substance Abuse and Mental Health Services Administration (SAMHSA) for its Registry of Effective Programs. It is the only school-based suicide prevention program that has been shown to reduce suicidality in a randomized, controlled study.

The program was developed with the assistance of, and endorsed by, leading school-based professional organizations such as the National Association of School Psychologists, National Association of School Nurses, American School Counselors Association and the National Association of Secondary School Principals.

The main teaching tool of the program is a video that teaches students how to identify symptoms of depression and suicidality in themselves or their friends and encourages help-seeking. The program's primary objectives are to educate teens that depression is a treatable illness and to equip them to respond to a potential suicide in a friend or family member using the SOS technique. Like the Heimlich Maneuver, SOS is an action-oriented approach instructing students how to **ACT** (**A**cknowledge, **C**are and **T**ell) in the face of this mental health emergency. A kit of materials is provided that includes a staff procedure manual and training video, student screening forms, an educational video and discussion guide, and brochures on suicide and depression for students and parents.

Since 2000, more than 1,000 schools have participated. Feedback from school coordinators includes the following positive trends:

- 90% agreed that the program brought students in need to the school's attention
- More than 94% agreed that the program improved communication about depression and suicide among students and between students and school personnel.
- Schools participating for the first time experienced a 150% increase in students seeking help.
- The program has an excellent safety profile.

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RESPONSE TO QUESTIONS OF SENATOR BINGAMAN FROM LAURIE FLYNN

NOTE: In order to ensure full and final scientific review, Laurie Flynn will provide additional information and research references to Senator Bingaman in the coming week.

Question 1. Access to treatment for mental illness is a serious problem in this country. Yet there is a reluctance to cover mental illnesses at the same level as physical illnesses. How important is health insurance parity between mental and physical illnesses in reducing the risk for suicidal behavior?

Answer 1. There is no known research that documents that lack of access to mental health treatment increases an individual's risk for suicidal behavior; we know, however, that the lack of health insurance parity creates a barrier to effective treatment for those at risk. One of the things that we do in our own program, the TeenScreen Program, is work with screening sites to ensure that the necessary and appropriate treatment is available in the community for youth found to be at risk and in need of mental health services.

Question 2. The New Freedom Commission on Mental Health and the Surgeon General's 1999 Report on Mental Health both identified a national shortage of men-

tal health professionals trained to treat mental illness in children and adolescents. How can we reduce this shortage?

Answer 2. While this is not an area which we have studied, we are appreciative of Senator Bingaman's sponsorship of S. 1223, the Child Health Care Crisis Relief Act. TeenScreen Program staff has heard anecdotes from our rural screening sites that the lack of mental health professionals in these areas has reached a critical mass.

Question 3. Adolescents with mood disorders, such as major depression and bipolar disorder, are at high risk for suicide. How effective are current treatments for early-onset mood disorders? How can we make evidence-based treatments available to more vulnerable young people?

Answer 3. A limited number of randomized controlled trials have shown that SSRIs, cognitive-behavioral therapy, and interpersonal therapy are all effective in depressed children and teens; more research needs to take place to better match treatments to children.

Treatments, however, are only effective if youth in need are identified and referred for treatment. Former Surgeon General David Satcher reported that 1 in 10 American children under the age of 18 has a mental illness severe enough to cause impairment. Sadly, while treatments are available, not all youth receive the care they need, and many of those suffering from depression or another mental disorder make a suicide attempt. According to the Centers for Disease Control, in 2001 suicide was the third leading cause of death for youth age 15–19, with more adolescents committing suicide than dying from all natural causes combined. The TeenScreen Program is an effective means of identifying youth at risk for mental illness and suicide and linking them to treatment, especially those silent sufferers who are not known to be ill and who might otherwise go without the care they need.

Question 4. Substance abuse is also a high-risk factor for suicide. What programs are most effective in reducing adolescent substance abuse?

Answer 4. While no rigorous, scientific studies have been conducted to compare substance abuse prevention programs, we do know that depression and substance abuse are frequently co-morbid; together, these disorders create a severely increased risk factor for suicide, particularly in adolescent males. In fact, almost all adolescent males who commit suicide suffer from depression and substance abuse disorders.

Question 5. Teenage suicides are always tragic, but there is a consistently high Native-American adolescent suicide rate and a recent dramatic increase in the African-American adolescent suicide rate. Do you recommend intense federally supported interventions to address the risk factors that result in these statistics?

Answer 5. In our work with the Native American and African-American communities, we have seen that these populations appear to be at high risk for suicide and may be committing suicide more frequently than other populations. Specifically, we have worked with a number of Native-American schools in New Mexico, through a partnership with the New Mexico Department of Health's Office of School Health and the University of New Mexico's Department of Psychiatry, and throughout the western United States, as well in the African-American community in New York and other urban areas of the country. One thing the government can do is make funding available, particularly in high risk and high impact communities, to accelerate the implementation of mental health screening so that at risk youth are identified and connected to treatment at an earlier point in their lives.

Question 6. Schools serve as gatekeepers for the early identification and referral of young people with mental illness. How can we prepare schools to serve more effectively in this role?

Answer 6. Youth mental health screening is one of the most effective means of early identification and referral of young people with mental illness in schools. Many schools, however, do not have the existing time, staff, or resources to implement screenings without outside support or consultation. In addition, Federal support for youth suicide prevention and school-based mental health services is scattered among many agencies and many programs. The Federal Government should fund a national coordinating center on youth mental health screening to provide training, technical assistance, and ongoing support to schools and to help States and national organizations develop screening efforts.

Question 7. Over 1,400 school-based health centers deliver primary preventive and early intervention services to more than a million children in 45 States. Mental health counseling is the leading reason for visits by students and the fastest grow-

ing component of school-based health care. How can we expand the availability of such services?

Answer 7. Although mental health counseling is the leading reason for visits by students, most school-based health centers do not have full time mental health counselors and thus cannot adequately meet the mental health needs of the students. Additional resources targeted towards mental health counseling needs to be provided to school-based health centers. Specifically, both the Department of Health and Human Services and the Department of Education should ensure that all School-Based Health Centers have a professionally staffed mental health component, including a mental health screening tool in order to help staff make the best use of limited resources.

RESPONSE TO QUESTIONS OF SENATOR DODD FROM LAURIE FLYNN

NOTE: In order to ensure full and final scientific review, Laurie Flynn will provide additional information and research references to Senator Dodd in the coming week as needed.

Question 1. Thank you very much for joining us. You said that "universal screening, when linked with referral to appropriate services, can significantly reduce the devastating impact of mental health problems on young lives." What other services has the TeenScreen Program worked in conjunction with? Are these school-based services, community-based services, or a mixture of both? Has TeenScreen been incorporated into any statewide youth suicide early intervention and prevention strategy?

Answer 1. While our national TeenScreen office has not formally worked in conjunction with other services, many of our sites throughout the country have. Every community that implements the TeenScreen Program does so in their own way and many of the screening programs are done in collaboration with a variety of other services provided in the school and in the community such as advocacy services, mental health awareness and educational services, and drug and alcohol prevention services. In addition, community partnerships have been formed at the local level with chapters of the National Alliance for the Mentally Ill; mental health associations; crisis lines; University departments of psychology, psychiatry, and social work; and family service associations; to name a few, to carry out screening.

TeenScreen is fortunate to be working in conjunction with several statewide youth suicide prevention strategies. In New York, another staff member of the TeenScreen Program and I are members of the New York State Suicide Prevention Council at the New York State Office of Mental Health. We are actively involved in the writing of the New York State suicide prevention plan.

In Oregon, TeenScreen has been noted in "The Oregon Plan for Youth Suicide Prevention: A Call to Action," prepared by the Oregon Department of Human Services. One of the plan's eight strategies is to "implement screening and referral services," and the TeenScreen program is listed as a "promising screening instrument."

In Florida, our partnership is an example of the relationship between youth suicide, mental illness, and substance abuse prevention. TeenScreen has been working with Governor Jeb Bush to help achieve his goal of reducing suicides in the State. We have specifically collaborated with James McDonough, Director of the Office of Drug Control and the State Suicide Prevention Task Force. In partnership with the University of South Florida we are piloting district-wide mental health screening of 9th graders in two counties. Staff has met with mental health professionals and community leaders, elected officials, advocates, the business community, and family organizations to build a base of support for media outreach and awareness.

In Nevada, the Department of Education recently announced plans to create a new office within the department, the Center for Health and Learning. The Center will, among other activities, be responsible for setting up a statewide program to oversee the TeenScreen Program in interested schools and districts. The Center's oversight will include the development, start-up, and implementation of TeenScreen sites as well as ongoing support, including planning support, coordination of provider services, and quality assurance guidance, for these new sites.

In New Mexico, we have had a collaborative relationship with the New Mexico Department of Health's Office of School Health and the University of New Mexico's Department of Psychiatry has led to successes on many fronts. Due to our success in the State, youth mental health screening is at the forefront of issues to be included in New Mexico's behavioral health restructuring plan, and have a great deal of support across State agencies.

In Ohio, we have been fortunate to work with Mike Hogan, Ph.D., Director of the Ohio Department of Mental Health, Chair of the President's New Freedom Mental Health Commission, and a member of our National Advisory Council. In February

2002, Commissioner Hogan initiated a statewide TeenScreen effort by soliciting five county mental health boards to be part of a pilot program. Over the next 10 to 18 months, the development of these screening sites was supported by staff at the TeenScreen Program as well as through a grant of $15,000 from the Department of Mental Health to each mental health board who is participating in the pilot program.

In Connecticut, we have worked in Wilton, Bridgeport, and most recently New Haven; I would be more than happy to discuss this work with you or your staff in detail at your convenience.

Question 2. You mentioned that TeenScreen can be implemented in other youth-oriented settings besides schools, such as residential treatment facilities, foster care settings, clinics, shelters, and drop-in-centers. Has TeenScreen been implemented in any of these settings? If so, how does it compare with the school-based programs?

Answer 2. Yes, TeenScreen has been successfully implemented in all of these settings. The model is always a bit different as the staffing and resources at each setting vary so much, however, the same fundamental process is used.

In clinical settings or drop-in centers (for example, a community, family, and youth clinic), youth are given the opportunity to be screened at intake, whether they come in for a routine physical, a broken wrist, or a mental health issue.We have several TeenScreen programs within Covenant House, which is a shelter for runaway and homeless youth. At Covenant House, screening is part of the intake process and this enables the shelter staff to immediately identify and address the needs of the youth who are suicidal. It also enables them to identify youth who have other mental health needs so that they can be further assessed and appropriately treated during their stay at the shelter.

We have also worked closely with Father Flanagan's Girls and Boys Town in Nebraska, where a version of the TeenScreen Program is administered at intake to every youth who enters the program. In addition, we are proud to have Fr. Val J. Peter, Executive Director of Girls and Boys Town, as a member of our National Advisory Council.

These "modified" screening programs, used at other settings, are no more or less effective than our school-based programs. We are trying to meet the kids where they are, making schools the most obvious choice to implement screening. Wherever kids show up, however, be it shelters, pediatrician's offices, or otherwise, they should have the opportunity to be assessed for mental health problems and linked with appropriate services.

RESPONSE TO QUESTIONS OF SENATOR REED FROM LAURIE FLYNN AND CHERYL KING

FOR LAURIE FLYNN: A number of panelists and Senator Clinton referred to difficulties in accessing treatment for mental illnesses as a serious problem in this country.

Question 1. What are the factors involved in creating this inability to access care?

Answer 1. There are many widely discussed difficulties in accessing treatment for mental illness, among them a lack of mental health providers, lack of insurance coverage, and a continued stigma against mental illness and mental health care. To the list, however, should be added accurate diagnosis. Without a complete overview of their mental health, teens can receive incomplete care and the limited resources of the delivery system can be misalllocated. While our nation's mental health professionals are doing a fantastic job at caring for our youth, most children and teens with mental health problems are not even known to be suffering. Early identification and prevention of youth mental illness, through screening, is one of the best ways to ensure that all youth receive a complete mental health overview.

Question 2. There is a reluctance to cover mental illnesses at the same level as physical illnesses. How important is parity between mental and physical illnesses in improving access to services and reducing the risk for suicidal behaviors?

Answer 2. There is no known research that documents that lack of access to mental health treatment increases an individual's risk for suicidal behavior; we know, however, that the lack of health insurance parity creates a barrier to effective treatment for those at risk. One of the things that we do in our own program, the TeenScreen Program, is work with screening sites to ensure that the necessary and appropriate treatment is available in the community for youth found to be at risk and in need of mental health services.

Question 3. Teenage suicides are always tragic but there is a consistently high rate among Native-American and African-American male adolescents as well as an apparent dramatic increase in the rate for military members returning from Iraq.

What data is available regarding the etiology or methods for preventing these unnecessary deaths?

Answer 3. In our work with the Native-American and African-American communities, we have seen that these populations appear to be at high risk for suicide and may be committing suicide more frequently than other populations. Specifically, we have worked with a number of Native-American schools in New Mexico, through a partnership with the New Mexico Department of Health's Office of School Health and the University of New Mexico's Department of Psychiatry, and throughout the western United States, as well as in the African-American community in New York and other urban areas of the country. One thing the government can do is make funding available, particularly in high risk and high impact communities, to accelerate the implementation of mental health screening so that at risk youth are identified and connected to treatment at an earlier point in their lives.

We don't yet have complete information about the suicide risk for military members returning from Iraq as not enough research has been done to look at protective factors and long-term outcomes. We are hearing anecdotes about the impact of ongoing conflict on the families at home, especially give the growing reliance on our National Guard. No known programs are in place to address the dislocation of family and distress caused by the call up of civilians in the National Guard and military reserve. We need to offer a mental health screening to children from military families to address their emotional state. We should also be offering mental health screening in military-base schools around the world. There is a real need for the Department of Defense to address this.

Question 4. What do you think can be done at a Federal level to alleviate this situation?

Answer 4. Overall, the government needs to fund efforts to offer all youth mental health screening; we cannot treat teens unless we know they are in need. In addition, the government can increase funding for suicide prevention research. There is still a lot to be learned.

FOR DR. KING: *Question 1.* What is the current data regarding firearm-related suicides?

Answer 1. The latest research shows that, for young people 15–24 years old, suicide is the third leading cause of death, behind unintentional injury and homicide. From 1980–1997, the rate of suicide among persons aged 15–19 years increased by 11 percent and among persons aged 10–14 years by 109 percent. From 1980–1996, the rate increased 105 percent for African-American males aged 15–19. Among persons aged 15–19 years, firearm-related suicides accounted for more than 60 percent of the increase in the overall rate of suicide from 1980–1997. Firearms are the most common method used in completed suicides among both adolescent boys and girls in our Nation.

Psychological research demonstrates that important risk factors for attempted suicide in youth are depression, alcohol (or other drug use), and aggressive or disruptive behaviors. Children are most frequently injured by firearms when they are unsupervised and out of school. These shootings tend to occur in the late afternoon, peaking between 4 p.m. and 5 p.m., during the weekend, and during the summer months and the holiday season.

Question 2. Where are the youngsters getting these guns from?

Answer 2. According to a recent study at the University of North Carolina, most teens that commit suicide do so with a gun they find in the home. Among the findings was that 36 percent of people reporting gun ownership and younger children in the home admitted to keeping their firearms loaded. Forty-five percent did not store their guns locked, and 57 percent failed to store them in a locked compartment. Among all ages in this country, 53 percent of all firearm deaths in 1998 were suicides.

Question 3. What kind of education and coordination can bring this under control?

Answer 3. The availability of firearms is a risk factor for youth suicide. Firearm-specific suicide prevention efforts should be directed toward education concerning firearm safety (safe storage) and the development of mechanisms for preventing the impulsive or dangerous use of firearms by youth (e.g., computerized coded locks). These prevention efforts must be combined with strategies that address the mental, alcohol/substance use and other disorders associated with suicidal incidents. We need to develop and coordinate safe and effective programs in educational settings for youth that address adolescent distress, crisis intervention and incorporate peer support for seeking help. It is essential that we develop and implement strategies

to reduce the stigma associated with mental illness, substance abuse, and suicide and with seeking help for such problems.

RESPONSE TO QUESTIONS OF SENATOR BINGAMAN FROM PANEL

Question 1. Access to treatment for mental illness is a serious problem in this country. Yet there is a reluctance to cover mental illnesses at the same level as physical illnesses. How important is health insurance parity between mental and physical illnesses in reducing the risk for suicidal behavior?

Answer 1. Certainly the widespread use of arbitrary and discriminatory limits on mental health benefits in group health plans contributes to suicide in this Nation. Demand-side restraints such as 50 percent coinsurance for using one's outpatient mental health benefits (vs. 20 percent for medical/surgical benefits) and day and visit limits on inpatient and outpatient care discourage early intervention. Untreated mental disorders may cascade into serious illness and suicidal intentions. For this reason virtually every national organization dedicated to suicide prevention has endorsed the Paul Wellstone Mental Health Equitable Treatment Act.

Question 2. The New Freedom Commission on Mental Health and the Surgeon General's 1999 Report on Mental Health both identified a national shortage of mental health professionals trained to treat mental illness in children and adolescents. How can we reduce this shortage?

Answer 2. In addition to Federal passage of the Campus Care and Counseling Act and the Child Healthcare Crisis Act, both of which have training components for mental and behavioral health professionals that work with children, the Graduate Psychology Education (GPE) Program warrants continued and expanded Federal support.

The GPE Program, established in fiscal year 2002, is the first and only Federal program dedicated to psychology education and training. Housed in the Bureau of Health Professions (Health Resources & Services Administration), it provides Federal funding to universities and training sites (i.e., health science centers, children's hospitals, V.A. hospitals) to train psychologists with an interdisciplinary approach for specializing with underserved populations, especially children and adolescents. The psychologists, while being trained with other health professionals such as social workers, psychiatrists, physicians, nurses, occupational therapists, provide free health care in underserved communities, primarily rural or inner city. The training for children's services includes violence prevention in preschool children, treating neurologically impaired children, preventing child abuse, dealing with children's learning problems, and treating depression and suicidal tendencies in teenagers. The psychologists who are trained through this funding and develop expertise in treating youth, will be placed in the underserved communities upon graduation and licensing.

Question 3. Adolescents with mood disorders, such as major depression and bipolar disorder, are at high risk for suicide. How effective are current treatments for early-onset mood disorders? How can we make evidence-based treatments available to more vulnerable young people?

Answer 3. Several evidence-based treatments are available for early-onset major depression. These include certain types of psychotherapy and antidepressant medication. In fact, a combination treatment of medication, short-term psychotherapy, and parental education is often recommended for youth because of the concomitant interpersonal, family, and/or school difficulties. These difficulties, as well as self-defeating behaviors and negative patterns of thinking, are addressed to improve functioning and avoid long-term negative consequences. Some youth require more prolonged treatment because of the severity of their illness or the presence of co-occurring alcohol/drug abuse or other disorders. Persons with one episode of major depressive disorder are at risk for recurrence.

Bipolar disorder is a chronic and severe illness, which requires long-term medication treatment (continuous). Youth with bipolar disorder can, however, usually be stabilized with appropriate treatment. A strategy that combines medication and psychosocial treatment is recommended to manage the disorder and its associated psychosocial impairment. Medications known as "mood stabilizers" are usually prescribed, with other medications added as necessary, generally for shorter periods. The psychosocial treatment may address healthy daily living patterns, coping and stress management, self-awareness of mood changes, and the importance of medication treatment adherence.

A physician may prescribe to youth a medication that has been FDA-approved for use in adults, but not children. Such "off-label" use is based on medication knowledge and clinical experience, and occurs because only a small number of medication

treatments for early-onset mood disorders have been systematically studied—in terms of safety and efficacy—in youth. The FDA has, however, been recommending appropriate studies in youth and encouraging drug manufacturers to conduct such studies. A current FDA investigation is addressing the appropriate use of antidepressants in children and adolescents.

Health insurance parity between mental and physical illnesses would enable us to take the biggest step toward making evidence-based treatments more available to vulnerable young people. Many families do not have sufficient resources to provide their children with adequate treatments. This is particularly true with early-onset bipolar disorder and severe forms of major depressive disorder that require more intensive and ongoing treatments. It is recommended that such parity be provided for evidence-based treatments. It is also recommended that incentives be provided for advanced professional training in the area of children's mental health, and that Federal funds be earmarked for the further development and improvement of evidence-based treatments for early-onset mood disorders.

Question 4. Substance abuse is also a high-risk factor for suicide. What programs are most effective in reducing adolescent substance abuse?

Answer 4. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health has established many model programs that have been found to be effective in reducing adolescent substance use. In fact, both SAMHSA and the Department of Education maintain registries of effective programs. Many of the programs target not only the youth, but their families as well. Effective programs incorporate various settings (i.e., school, home, community) and target reducing risk factors and increasing the presence of protective factors. Three model programs will be highlighted for their effectiveness in reducing substance use among youth.

The Brief Strategic Family Therapy program, developed at the University of Miami, is a short-term, problem focused therapeutic intervention targeting children and adolescents 6 to 17 years old, that improves behavior by reducing drug use and its associated behavior problems. It also alters family member's behaviors that are linked to protective and risk factors. Outcomes of this program include 75 percent reduction in marijuana use, 42 percent improvement in conduct problems, 58 percent reduction in association with antisocial peers as well as improvements in family functioning, youth self-control, and family communication skills.

The Across Ages program, developed at Temple University, is a school- and community-based drug prevention program for youth 9 to 13 years old that pairs older adult mentors (age 55 and above) with youth making the transition to middle school. Outcomes of this community-based intervention include decreased alcohol and tobacco use, increased knowledge about and negative attitude toward drug use, increased school attendance, as well as lasting relationships with nurturing and mentoring adults.

The Families That Care—Guiding Good Choices program, developed at the University of Washington, Seattle, is a multimedia program that gives parents of children in grades four through eight (8 to 13 years old) the knowledge and skills needed to guide their children through early adolescence. Outcomes of the program include reduced substance use 2 years after the intervention was completed, significantly lower rates of increase in initiation of drinking to drunkenness and marijuana use over a 4-year period, less drinking in the past month (relative reduction of 40.6 percent) and increased parent communication of substance abuse rules and consequences.

Many effective programs are solidly evidence-based. Policies that encourage the implementation of effective programs, the dissemination of such programs to all localities, and the adaptation of model programs to achieve maximal effectiveness in differing locations, cultures, and racial and ethnic groups are recommended.

Question 5. Teenage suicides are always tragic, but there is a consistently high Native-American adolescent suicide rate and a recent dramatic increase in the African-American adolescent suicide rate. Do you recommend intense federally supported interventions to address the risk factors that result in these statistics?

Answer 5. Federally supported interventions to reduce the high suicide rates among racial and ethnic minorities, particularly among American Indian and Alaskan Native adolescents, are critically needed. American Indian/Alaska Native adolescents are more than twice as likely to commit suicide as any other racial/ethnic group. During 1981 to 1998, the suicide rate for African-American youths aged 10 to 19 years increased from 2.9 to 6.1 per 100,000 (with increase occurring among males). This is a tragic increase within a relatively short period of time. Although African-American males continue to have lower suicide rates than Caucasian males,

the gap between these two suicide rates has closed significantly. Among high school students, 11 percent of all Hispanics and 15 percent of Hispanic females reported attempting suicide in the past 12 months. These attempts are associated with substantial distress and impairment, but do not seem to be associated with a higher rate of completed suicide.

These staggering statistics show the strong need for evidence-based interventions at the Federal level that would address some of the risk factors associated with youth suicide. Primary risk factors to address among racial and ethnic minorities are alcohol and other substance abuse, depression, acculturative stress, school dropout and other social problems (i.e. high unemployment), and availability of evidence-based health care. Programs establishing quality screening and early intervention in readily accessible, low-stigma settings are of critical importance. These intervention programs need to be implemented within a cultural context.

Question 6. Schools serve as gatekeepers for the early identification and referral of young people with mental illness. How can we prepare schools to serve more effectively in this role?

Answer 6. Given schools' day-to-day contact with children from an early age, they are ideally suited to identify children with mental health problems and to provide needed services or community referral, as appropriate. However, due to limited resources, schools too often fail to identify children in need of mental health intervention until the situation reaches crisis stage. Training school personnel to recognize mental health problems early on and providing screening programs to identify children at risk would allow for early intervention when children are younger and/or when problems are less acute.

Developmental, environmental, and cultural issues would need to be addressed in the training and screening programs. An educated school environment—with students, teachers, and others aware of the signs of depression and suicide risk—offers a safety net in terms of the recognition and referral of "at risk" students. It is also critical to increase the number of school-based mental health professionals, including counselors, psychologists, social workers, and nurses, to meet the increased need for student mental health services and to refer to community providers, when appropriate.

Question 7. Over 1400 school-based health centers deliver primary preventive and early intervention services to more than a million children in 45 States. Mental health counseling is the leading reason for visits by students and the fastest growing component of school-based health care. How can we expand the availability of such services?

Answer 7. Mental health counseling is a vital component of school-based health care, but is not available to many students. The critical role played by school mental health services is conveyed in the final report of the President's New Freedom Commission on Mental Health: "Clearly, strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary pain and suffering, and help ensure academic achievement." By locating mental health services in schools, it is also possible to overcome many barriers to care, including lack of health insurance, transportation difficulties, language differences, and stigma, which are often faced by low-income and non-English speaking families, in particular.

School health programs should be established in all States and territories and in the 25 largest local educational agencies. The availability of such services can be increased through greater financial support for such Department of Education programs as Title I and the Elementary and Secondary School Counseling Program and Medicaid, as well as through targeted initiatives that might be offered by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration.

According to the Centers for Disease Control and Prevention, it is vital to extend the eight components of school health (which include "Counseling, Psychological and Social Services") to all American children through coordinated school health programs, in keeping with the goals of the Nation's key national health planning effort, *Healthy People 2010*.

AN OUTCOME EVALUATION OF THE *SOS* SUICIDE PREVENTION PROGRAM

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AUTHOR CONTRIBUTIONS

R. Aseltine conceived of the study and took primary responsibility for the analysis of data and writing of this manuscript. R. DeMartino contributed to the design of the study, the interpretation of the data, and reviewed drafts of this manuscript.

HUMAN PARTICIPANT PROTECTIONS

The procedures used to collect these data were approved by the University of Connecticut Health Center's Institutional Review Board.

AN OUTCOME EVALUATION OF THE SOS SUICIDE PREVENTION PROGRAM ABSTRACT

Objectives. This study examined the effectiveness of the *Signs Of Suicide* prevention program in reducing suicidal behavior.

Methods. 2,100 students in five high schools in Columbus, Georgia and Hartford, Connecticut were randomly assigned to intervention and control groups. Self-administered questionnaires were completed by students in both groups approximately 3 months after program implementation.

Results. Significantly lower rates of suicide attempts and greater knowledge and more adaptive attitudes about depression and suicide were observed among students in the intervention group. The modest changes in knowledge and attitudes partially explained the beneficial effects of the program on suicide attempts.

Conclusions. *SOS* is the first school-based suicide prevention program to demonstrate significant reductions in self-reported suicide attempts in a study utilizing a randomized experimental design.

Keywords: Suicide, depression, prevention, adolescents, evaluation, screening.

Suicide among young people is one of the most serious public health problems facing the United States. According to the National Center for Health Statistics, the suicide rate for youth and young adults aged 15–24 has tripled since 1950, and suicide is now the third leading cause of death in this age group.[1,2] Although it is difficult to obtain reliable estimates because of the accompanying stigma, the incidence of suicide attempts among adolescents may exceed 10% over a 6–12 month period.[3,4]

A number of diverse approaches to suicide prevention have been introduced into high school curricula in the past 15 years.[5,6,7] Few, however, have been subjected to rigorous evaluation, and those that have been scientifically evaluated have produced mixed results. On the positive side, a suicide awareness curriculum developed by Spirito and colleagues yielded a significant increase in knowledge concerning suicide and small but statistically significant reductions in the use of maladaptive coping strategies among ninth grade students.[8] Similarly, increases in personal control, problem-solving coping, self-esteem and family support and decreases in depression were observed among at-risk high school students who were exposed to brief supportive counseling interventions developed by Randell et a1.[9] These modest successes are overshadowed, however, by several other studies that have failed to observe any effects of such interventions on students' attitudes or behaviors.[10,11]

A relatively new approach to reducing the incidence of suicide among adolescents is found in *SOS: Signs of Suicide*. This school-based prevention program incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicidal behavior.[12] In the didactic component of the program, *SOS* promotes the concept that suicide is directly related to mental illness, typically depression, and that it is not a normal reaction to stress or emotional upset.[13–17] Youths are taught to recognize the signs of suicide and depression in themselves and others and the specific action steps needed to respond to those signs. The objective is to make the action step—ACT—as instinctual a response as the Heimlich maneuver and as familiar an acronym as "CPR." ACT stands for Acknowledge, Care, and Tell. First, ACKNOWLEDGE the signs of suicide that others display and take them seriously. Next, let that person know you CARE about him or her and that you want to help. Then, TELL a responsible adult.

The program's teaching materials consist of a video (featuring dramatizations depicting the signs of suicidality and depression, recommended ways to react to someone who is depressed and suicidal, as well as interviews with real people whose lives have been touched by suicide) and a discussion guide. Students are also asked to complete the Columbia Depression Scale, a brief screening instrument for depression derived from the Diagnostic Interview Schedule for Children.[10] The screening form is scored by the students themselves; a score of 16+ on the CDS is considered a strong indicator of clinical depression, and the scoring and interpretation sheet accompanying the screening form encourages students with such scores to seek help immediately. Each school provides a description of the resources available to students who wish to seek assistance.

In sum, the *SOS* program aims to reduce suicidal behavior among adolescents through two primary mechanisms. First, the educational component of the program is expected to reduce suicidality by increasing students' understanding and recognition of depressive symptoms in themselves and others, and by promoting more adaptive attitudes toward depression and suicidal behavior. Second, the self-screening component of the *SOS* program helps students to assess and evaluate the depressive symptoms and suicidal thoughts they might be experiencing and prompts them to seek assistance in dealing with these problems. Such help-seeking need not be limited to referral for treatment by a mental health professional, which is likely to be constrained by such factors as the availability and accessibility of providers, health insurance coverage, and social stigma, but should also be manifested in help-seeking directed at the "indigenous trained caregivers" in the school environment (teachers, guidance counselors), as well as loved ones.[18]

In addition to its use of multiple suicide prevention strategies, the *SOS* program offers other potential advantages. First, the focus on peer intervention is developmentally appropriate for the target age-group.[19,7,20] During adolescence peers become the primary sphere of social involvement and emotional investment for most youths.[21,22] By teaching youths to recognize the signs of depression and empowering them to intervene when confronted with a friend who is exhibiting these symptoms, *SOS* capitalizes on a key feature of this developmental period. Second, the program can be implemented on a school-wide basis by health educators with relative ease. Data from schools offering the SOS program during the 2001–2002 school year indicate that it can be implemented with minimal staff training and does not unduly burden teaching, counseling, or administrative staff.[23] Other suicide prevention programs that include mental health screening can be costly, difficult, and time-consuming to implement.[13]

This article presents data from an outcome evaluation of the *SOS* program conducted during the 2001–2002 school year in five high schools in Hartford, Connecticut and Columbus, Georgia. The primary goal of this research was to assess the short-term impact of the program on suicidal behavior, help-seeking, and knowledge of and attitudes toward depression and suicide in a diverse student population.

METHODS

This study involved 2,100 public school students in three high schools in Hartford, CT and two high schools in Columbus, GA. As indicated by the demographic profile of the sample (Table 1), these schools provide a racially mixed and economically diverse sample of youths. The three Hartford schools (N = 1435) are dominated by economically disadvantaged youth from diverse racial and ethnic backgrounds: approximately 59% of the Hartford sample was of Latino origin and 20% of students were Black. Twenty percent of Hartford students have been placed in a remedial English or bilingual program during high school. In contrast, the racial backgrounds

of students in the Columbus, GA schools (N = 665) are predominately White and Black, with most of these students living in working- to middle-class families.

TABLE 1.
DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE BY CITY

	Hartford, CT	Columbus, GA
Race/Ethnicity		
White, non-Hispanic	6%	39%
Black, non-Hispanic	20	37
Hispanic	59	8
Multiethnic	9	12
Other	6	5
	100% (1363)	100% (655)
Gender		
Male	47	52
Female	53	48
	100% (1382)	100% (659)
Grade		
Freshman	35	100
Sophomore	30	0
Junior	18	0
Senior	18	0
	100 % (1352)	100 % (655)
ESL During High School		
No	80	85
Yes	20	15
	100% (1367)	100% (655)

The experimental design consists of randomized treatment and control groups and post-test only data collection. In 4 of the 5 participating schools, students were randomly assigned to health (in Hartford) and social studies (in Columbus) classes by a computerized scheduling program. (Only freshmen classes were eligible to participate in the Columbus sites). Because the semester in which students were assigned to these half-year classes was determined randomly, all students taking these classes during the first half of the school year were assigned to the treatment group and received the program over a 2-day period from October through November 2001. Students taking these classes during the second half of the school year were assigned to the control group and did not receive the program until after the evaluation was completed. The one exception to this, a technical-vocational high school in Hartford; clusters students in health classes according to their major area of study, and class composition does not change at midyear. For this school random assignment of classes to intervention and control conditions was achieved using a coin flip. Because the same teachers and same classrooms were used for both intervention and control conditions in all 5 schools, a number of potential concerns associated with the assignment of classrooms to experimental conditions were minimized.[24]

Students in both the treatment and control groups were asked to complete a short questionnaire in a group setting during class time approximately 3 months following the implementation of the program. Trained interviewers from the University of Connecticut's Center for Survey Research and Analysis and Columbus State University read aloud the questions to each class, and students recorded their confidential written responses on the anonymous questionnaires. Parents were notified in writing about the objectives of the study and were invited to contact their respective schools with questions or to withdraw their child from the study. The procedures used to collect these data were approved by the University of Connecticut Health Center's Institutional Review Board. Questionnaires were completed by 2,100 of the 2,258 students eligible for the study (Control N = 1073, Treatment N = 1027), resulting in an overall response rate of 93%.

Measures and Instruments

The questionnaire included items relevant to three specific classes of outcomes: (1) self-reported suicide attempts and suicidal ideation; (2) knowledge and attitudes about depression and suicide; and (3) help-seeking behavior. The primary endpoint for this study is a single-item measure of self-reported *suicide attempts* taken from the CDC's Youth Risk Behavior Survey (YRBS): "During the past 3 months, did you actually attempt suicide (yes or no)."[4] *Suicidal ideation* was also assessed with a question taken from the YRBS: "During the past 3 months, did you ever seriously consider attempting suicide (yes or no)." The measures of knowledge and attitudes about depression and suicide were adapted from instruments previously used to evaluate school-based suicide prevention programs.[8,10] *Knowledge of depression and suicide* consisted of 10 true-false items that reflect the central themes of the *SOS* program (e.g., "People who talk about suicide don't really kill themselves"; "Depression is an illness that doctors can treat"). Scores on this variable reflect the number of correct answers. The measure of *attitudes toward depression and suicide* was an 8 item summary scale assessing attitudes toward suicidal people and suicidal behaviors (e.g., "If someone really wants to kill him/herself, there is not much I can do about it"; "If a friend told me he/she is thinking about committing suicide, I would keep it to myself"). Responses to these questions ranged from "strongly disagree" to "strongly agree" on a five point scale, with higher values indicating more adaptive attitudes about depression and suicide (Cronbach's alpha = .74). Three separate questions were used to assess *help-seeking behavior*. Students were asked whether in the past 3 months, ". . . you received treatment from a psychiatrist, psychologist, or social worker because you were feeling depressed or suicidal (yes or no)", whether ". . . you talked to some other adult (like a parent, teacher or guidance counselor) because you were feeling depressed or suicidal (yes or no)", and whether ". . . you talked to an adult about a friend you thought was feeling depressed or suicidal (yes or no)."

Subjects with missing values on any variable in a particular analysis were excluded from that analysis. Although 84 youths assigned to the treatment group did not actually participate in either of the central elements of the program (the video and depression screening) due mainly to absences from school, they were retained in the analysis in order to estimate "intention to treat" effects. After exclusions for missing data, the effective sample size for these analyses ranged between 1,894 and 1,912.

Descriptive statistics for all dependent variables used in this analysis are presented in Table 2, separately by treatment status.

TABLE 2.

DESCRIPTIVE CHARACTERISTICS OF DEPENDENT VARIABLES

	Control (N = 1073)	Treatment (N = 1027)	Total Sample (N = 2100)	Valid N
	%	%	%	
Treated for depression/ suicidal ideation	9.9%	8.5%	9.2%	2039
Talked with adult about depression/suicidal ideation	18.7	15.9	17.3	2041
Talked with adult about friends' emotional problems	13.0	11.9	12.4	2042
Suicidal ideation past three months	12.2	10.1	11.2	2034
Suicide attempt past three months	5.4	3.6	4.5	2042
	Mean (SD)	Mean (SD)	Mean (SD)	
Knowledge of depression/suicide	6.49 (1.68)	7.18 (1.68)	6.67 (1.97)	2090
Attitudes toward depression/suicide	3.80 (.658)	4.05 (.644)	3.93 (.662)	2041

RESULTS

Comparability of Treatment and Control Groups

Preliminary analyses were conducted to assess the comparability of treatment and control groups in terms of race/ethnicity, gender, grade, and ESL status. Chi-square tests revealed no differences in the composition of treatment and control groups by race or gender. However, significant differences were observed for grade (chi-square = 23.6, df = 3) and ESL status (chi-square = 7.8, df = 1). Concerning grade, 10th grade students were slightly more likely to be assigned to the treatment group (e.g., 58% of 10th grade students were in the treatment group versus an expectation of 50%), while freshmen were slightly less likely to be assigned to the treatment group (44% in treatment). Concerning linguistic status, only 40% of those who had taken ESL or bilingual classes during high school were assigned to the treatment group.

Assessing the Effects of the SOS Program

To account for the assignment of classrooms to experimental conditions, multivariate analyses of program effects were performed using HLM 5.[25] HLM was developed to address generic problems in the analysis of hierarchical data structures, that is, data in which characteristics of one unit of analysis (e.g., individuals) are nested within, and vary among, larger units (e.g., social groups or contexts). In this analysis the effect of exposure to the SOS program on each outcome variable was estimated in a two-level HLM model, where students (the level 1 unit of analysis) were nested with classrooms (the level 2 unit of analysis). The basic level 1 model for these outcomes was:

$$\mathbf{Y}_{ij}=B_{0j}+B_{1j}FEMALE_{ij}+B_{2\text{-}5j}RACE_{ij}+B_{6j}ESL_{ij}+B_{7\text{-}9j}GRADE_{ij}+e_{ij}$$

where Y represents the predicted value on each outcome variable for each individual *i* in classroom *j*; *FEMALE*, *RACE*, and *ESL* represent a series of dummy variables for the demographic control variables included in the analysis; and e represents random error. To reduce the error variance in the outcome measures and control for differences in the composition of the treatment and control groups,[26] all level 1 models include dummy variables for race/ethnicity (Black non-Hispanic, Hispanic, Multiethnic, Other Race vs. White non-Hispanic), gender (Female vs. Male), grade (10th, 11th, 12th vs. 9th), and ESL status (ESL vs. no ESL).

Because exposure to the SOS program was determined at the classroom level, treatment effects were assessed for each outcome by inserting a dummy variable for exposure to the program into the level 2 equation for the level 1 intercept term:

$$\mathbf{B}_{0j}=G_{00}+G_{01}TREATMENT_j+U_{0j}$$

The random error in this equation (U0j) represents residual variability in treatment effects across classrooms. All demographic control variables were modeled as fixed effects (i.e., $B_{1j} = G_{10}$).

TABLE 3.

EFFECTS OF SOS PROGRAM ON STUDENTS' KNOWLEDGE OF AND ATTITUDES TOWARD DEPRESSION AND SUICIDE, HELP SEEKING, AND SUICIDAL IDEATION AND SUICIDE ATTEMPTS

	Attempts		Ideation		Knowledge		Attitudes		Treatment		Adult		Adult/friend	
	B	SE	B	SE	B	SE	B	SE	B	SE	B	SE	B	SE
Intercept	-3.447*	(.133)	-2.196*	(.078)	6.803*	(.054)	3.914*	(.091)	-2.459*	(.094)	-1.759*	(.081)	-2.114*	(.074)
SOS Program	- 467*	(.207)	-.272	(.147)	.689*	(.109)	.255*	(.038)	-.217	(.181)	-.233	(.146)	-.147	(.138)
Female	1.022*	(.313)	.764*	(.183)	.349*	(.077)	.136*	(.031)	.719*	(.189)	1.266*	(.193)	1.152*	(.165)
Hispanic	-.193	(.218)	-.245	(.144)	-.626*	(.108)	.097*	(.038)	-.147	(.299)	.091	(.158)	.132	(.186)
Black	-1.478*	(.378)	-1.027*	(.202)	-.589*	(.104)	.039	(.032)	-.999*	(.288)	-.415*	(.187)	-.388	(.199)
Multiracial	-.025	(.392)	-.095	(.232)	-.432*	(.145)	-.038	(.054)	-.147	(.299)	.344	(.214)	-.138	(.274)
Other Race	-1.307*	(.659)	-.510	(.342)	-.495*	(.194)	.050	(.070)	-.692	(.388)	.032	(.292)	.520	(.392)
ESL	.753*	(.273)	-.113	(.198)	-.569*	(.103)	-.029	(.086)	.495*	(.177)	.332*	(.155)	.314	(.170)
Sophomore	-.434	(.337)	.117	(.191)	.176	(.137)	-.040	(.039)	-.217	(.288)	-.595*	(.201)	-.057	(.206)
Junior	-.540	(.438)	-.387	(.306)	.228	(.151)	.057	(.059)	-.071	(.268)	-.132	(.193)	-.141	(.235)
Senior	-.281	(.426)	-.016	(.226)	.336	(.142)	.050	(.054)	.105	(.251)	-.166	(.208)	-.115	(.221)
ICC	.000		.002		.088		.071		.011		.011		.000	

Note. ICC is the intraclass correlation coefficient for each outcome.

* $p < .05$

The effects of the SOS program on students' knowledge of and attitudes toward depression and suicide, help-seeking behavior, and suicidal ideation and self-reported suicide attempts are presented in Table 3. For the analysis of attitudes and

knowledge, this table presents coefficients from a standard two-level HLM analysis; for help-seeking behavior, suicidal ideation, and suicide attempts, coefficients are derived from nonlinear two-level HLM models using the logit link function. The top row in Table 3 presents the effects of exposure to the *SOS* program on the various outcome measures included in this study. First and most importantly, the coefficients presented in column 1 of Table 3 indicate that exposure to the *SOS* program was associated with significantly fewer self-reported suicide attempts. The coefficient for the effect of the program on attempts is −.467, which when converted to an odds ratio indicates that the youths in the treatment group were approximately 40% less likely to report a suicide attempt in the past 3 months relative to youths in the control group (i.e., OR = $e^{-.467}$ = .628). The magnitude of the difference between the treatment and control groups is also indicated in the descriptive statistics presented in Table 2, as the rate of self-reported suicide attempts among students in the control group was 5.4% compared to only 3.6% among students in the treatment group.

Similarly, exposure to the *SOS* program resulted in greater knowledge of depression and suicide and more adaptive attitudes toward these problems (columns 3 and 4). The effects of the program on knowledge and attitudes were modest in magnitude, resulting in effect sizes of slightly more than a third of a standard deviation (e.g., knowledge: .689/1.98 =.35). The effects of the SOS program on both attitudes and knowledge remained statistically significant at the .0071 and .0083 levels, respectively, when Holm adjustments were applied to correct for multiple tests involving these secondary endpoints.[27,28] In contrast, the effects of the *SOS* program on help-seeking behavior did not achieve statistical significance. The negative coefficients for treatment effects in columns 3, 4, and 5 of Table 3 indicate that the treatment group was slightly less likely than the control group to seek help for emotional problems, but these effects did not achieve statistical significance at either a nominal or corrected .05 alpha level. Finally, although the descriptive statistics in Table 2 indicate lower levels of suicidal ideation among the treatment group, this difference fell short of statistical significance at the .05 level in the full multilevel model (column 2 of Table 3).

Concerning the impact of the demographic control variables on these outcomes, the patterns observed in Table 3 are consistent with those observed in national data from the 1999 Youth Risk Behavior Surveys.[4] The female coefficients in these models indicate that girls had significantly greater knowledge and more constructive attitudes about depression and suicide, were more likely to seek help when depressed and to intervene on behalf of friends, and were significantly more apt to report suicidal ideation and suicide attempts in the past 3 months than are boys.[29] Students in high school ESL programs had less accurate knowledge about depression and suicide, and had a higher prevalence of self-reported suicide attempts. However, ESL status was positively related to help-seeking, as students in these programs were more likely to seek treatment or talk with an adult when feeling depressed.

Significant effects of race/ethnicity on knowledge of depression and suicide, two of the help-seeking outcomes, and suicidal ideation and self-reported suicide attempts were also observed. Whites tended to be more knowledgeable about depression and suicide than those in other race and ethnic categories. However, Black students reported lower rates of suicidal ideation and suicide attempts than Whites and were less likely to seek professional help for these problems, both of which are consistent with previous epidemiologic research showing lower rates of suicidal ideation and depression among Blacks.[1,4] A reparameterization of the models presented in Table 3 (by including a dummy variable for White racial status and removing the Black term) indicated that Blacks also had significantly lower rates of suicidal ideation, self-reported suicide attempts, and professional help-seeking than Hispanics. Finally, differences in these outcomes by grade did not exceed what would be expected by chance (only 1 significant effect out of 21 contrasts).

Finally, the intraclass correlation coefficient for each outcome variable is presented in the bottom row of Table 3. The coefficients range from nearly 0 for self-reported suicide attempts, suicidal ideation, and talking to an adult about a troubled friend, to a high of .07 − .09 for the measures of knowledge and attitudes. These coefficients indicate that there is a high degree of independence among observations within classrooms for each outcome variable; at the most only 7–9% of the variance in these outcomes occurs at the classroom level.

EXPLAINING THE EFFECTS OF THE SOS PROGRAM ON SUICIDE ATTEMPTS

As mentioned in the Introduction, the impact of the *SOS* program on suicidal behavior may be due in part to its role in fostering greater knowledge and more constructive attitudes about depression and suicide. To examine the role of knowledge

and attitudes in explaining the effects of the *SOS* program on suicidality, these 2 measures were included as predictor variables in the level 1 model for self-reported suicide attempts. Results of this analysis are presented in Table 4. More adaptive attitudes toward depression and suicide and greater knowledge of depression and suicide were both significantly associated with a lower probability of self-reported suicide attempts. Controlling for these variables substantially reduced the effect of the *SOS* program on self-reported attempts, as the coefficient capturing the effect of the program on this outcome was reduced by approximately 40 percent (i.e., $[(-.467)-(-.264)]/-.467$) when these variables were controlled and was no longer statistically significant. Although there is some casual ambiguity regarding the associations between these concurrent measures of attitudes and behavior, this analysis suggests that a substantial portion of the effect of the *SOS* program on self-reported suicide attempts may be explained by improving subjects' understanding and attitudes about depression and suicide.

TABLE 4.

EXPLAINING THE EFFECTS OF THE SOS PROGRAM ON SUICIDE ATTEMPTS

	Suicide Attempts			
	B	SE	B	SE
Intercept	-3.447	(.133)	-3.615	(.146)
SOS Program	-.467*	(.267)	-.264	(.207)
Knowledge	--	--	-.195*	(.055)
Attitudes	--	--	-.605*	(.165)

Note. All models control for sex, race, grade, and ESL status.
* $p < .05$

DISCUSSION

It is clear from these data that the *SOS* suicide prevention program had a substantively important short-term impact on the attitudes and behavior of high school-aged youth in high-risk settings. By significantly reducing rates of self-reported suicide 2001 school year found evidence that the number of youths seeking assistance from school personnel, either because of their own emotional problems or those of friends, is generally lower in urban communities. Second, there are several barriers to help-seeking that are specific to schools involved in this study, particularly in Hartford. Administrators in the Hartford schools reported a serious shortage of staff available to assist students with mental health concerns. Moreover, a series of informal discussions conducted in 12 classes from three Hartford schools several months following exposure to the program revealed that students are unlikely to seek out school personnel to discuss emotional problems due primarily to confidentiality concerns. Instead, students reported that friends were the first people they would turn to when feeling depressed, a finding which is corroborated in previous research.[7]

Some may question the rates of self-reported suicide attempts in this sample (4.5% over a 3 month period), which appear to be somewhat higher on an annualized basis than recent 1 year national prevalence estimates from the CDC's Youth Risk Behavior Surveys (8.5–10.5%).[4] Although there is ample reason to expect higher rates of suicidal behavior in this sample due to the predominance of seriously disadvantaged youth at high-risk for depression, substance abuse, and suici-

dal behavior, research has shown that one cannot "annualize" data collected using shorter recall periods by simple multiplication (i.e., multiplying the 3 month prevalence by 4). For example, epidemiologic data from the National Comorbidity Survey on the course of major depression among adolescents indicate that the 1 month prevalence rate for major depression is approximately one half that observed for the past year due to chronicity and the lengthy duration of depressive episodes.[30] Applying this logic to the 3 month prevalence rates obtained in this study yields annual prevalence rates that are not inconsistent with the national data published by the CDC. No suicides were reported in any of the participating schools during the study period.

Finally, this study has a number of limitations that must be acknowledged. First, the present evaluation should be replicated in more socially and geographically diverse locations. The significant positive impact of this program on high-risk youth in urban settings is certainly an important finding, but replication in rural and suburban settings containing fewer disadvantaged youth is necessary to determine whether these findings are generalizable to a broader population. Second, the effects of this program were observed over a very short post-intervention period. A longer term follow up of youths exposed to the *SOS* program is necessary to determine whether the observed effects are enduring. Third, pretest measures of the outcomes assessed in this study would add confidence that the assignment of classes to experimental conditions resulted in equivalent groups. Fourth, this study has revealed some of the challenges facing school-based programs designed to foster help-seeking among students. Concerns regarding confidentiality may be acting to suppress interaction between students and school personnel regarding serious mental health concerns, which may lead to acute problems among youths in high-risk settings who possess limited parental and financial resources. Relatedly, future research should seek to assess the degree to which help-seeking among emotionally troubled adolescents is directed toward friends and siblings, and assess as well the impact of support received in these relationships on suicidal behavior. Finally, readers may question whether our results are tainted by the desire of those exposed to the program to provide what they perceive to be the "right answers" attempts in the 3 months following exposure to the program, *SOS* appears to have had a substantial impact on the ultimate target of suicide prevention programs. Efficacy in deepening students' knowledge of and promoting more adaptive attitudes toward depression and suicide was also demonstrated, and further analysis highlighted the importance of these variables in potentially accounting for the beneficial effects of the *SOS* program on self-reported suicide attempts. Although further research is necessary to determine whether the effects of the *SOS* program are enduring, the short-term impact of this program on students' attitudes and behavior was noteworthy. This is the first school-based suicide prevention program for which a reduction in self-reported suicide attempts has been documented with a randomized experimental design.

In contrast, significant effects of the program on suicidal ideation and help-seeking were not observed. The fact that self-reported suicide attempts were reduced by a much greater extent than were thoughts of suicide is most likely a result of the *SOS* program's relatively greater emphasis on action and behavior. Reductions in levels of suicidal ideation are expected to be an ancillary benefit of *SOS*, particularly if the program's efforts to encourage active engagement and communication with peers around these issues foster a general mobilization of peer support.[22] However, suicide prevention programs that place greater emphasis on personal growth and positive youth development will likely have a greater relative impact on outcomes such as depressed mood and suicidal ideation. While significant effects of the intervention on help-seeking behaviors were expected, further investigation revealed several likely explanations for the absence of program effects on help-seeking for this particular sample. First, a process evaluation involving site coordinators at schools implementing the *SOS* program during the 2000—when responding to survey questions about their attitudes and behavior. As discussed in the introduction, however, suicide prevention programs have historically demonstrated very little in the way of efficacy. Adolescents have not felt compelled to pick what they feel are the "right answers" in prior research, and there does not appear to be anything unique about this sample that would lead students to do so here. Second, if students are endorsing the right answers as opposed to their true feelings and experiences, then it is reasonable to expect that treatment effects would be observed across the board. The selective impact of this program on the various outcomes assessed in this study provides fairly strong evidence to the contrary.

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PREPARED STATEMENT OF FRAN M. GATLIN

Good morning. Thank you, Chairman DeWine, Ranking Member Kennedy, and all the members of the subcommittee for hosting this hearing and giving me the opportunity to testify on this important issue. My name is Fran Gatlin. I have been a practicing school psychologist for more than 28 years. I am currently working at Robinson High School, in Fairfax County, Virginia, which serves more than 3,000 students. Professionally, I am a Nationally Certified School Psychologist and a member of the National Association of School Psychologists and the American Association of Suicidology.

It is encouraging that I have been asked to share with you my role as a school-based mental health professional in the effort to help prevent suicide among our children and adolescents. I am fairly confident that my experience reflects that of many of my colleagues across the country. The role of schools in the identification of student mental health needs, including the prevention of suicide, cannot be underestimated. Indeed, schools have been identified by almost every stakeholder as a critical component in an effective system of mental health care that also includes families, community services, and the medical profession.

Why? Because virtually every community has a school, and most children and youth spend on average of 6 hours a day there under the care of familiar, trained professionals. We have the opportunity to observe students at risk, connect with them and their families, and get them the help they need. Equally important, we can create an environment in which students feel safe and able to seek help. We can use the learning environment to educate students and their parents about the signs and treatment of suicide risk and other mental health problems. And, as we are learning is so important, we can help students understand the vital role they play in preventing the suicide of a friend or classmate by telling an adult when they believe a peer is at risk.

But we need the resources to do this important work.

Professionally, I became deeply concerned about suicide prevention over 10 years ago. I noticed that students who made suicide attempts or had a psychiatric hospitalization had no diagnosis or treatment before that crisis. So I organized, advertised and offered panel discussions for parents on adolescent depression and suicide. No matter how I advertised these events there were never as many parents in attendance as panel members there to speak to them. I interpreted that outcome as reflecting parental denial that these were issues that could affect their families.

This lack of awareness is a serious problem given the scope of the epidemic. Suicide is the third leading cause of death of students aged 10-18. It ranks second among college students. In my state of Virginia, the rate of suicide among high school age youth is approximately one per week. In the United States 30,000 people die of suicide each year. In the world, the suicide rate is approaching a million. As former Surgeon General, Dr. David Satcher said, suicide is the most preventable form of death, but it requires an investment to save lives. The public needs to be educated about suicide. People need to understand that most suicide results from untreated depression and that depression is a treatable illness. Surveys tell us that as many as one in five teenagers seriously considers suicide. 520,000 teenagers require medical services as a result of suicide attempts each year. The psychological pain implied in these numbers is sobering.

The reasons for this pain are numerous and ultimately individual to each person. But current thinking is that among teenagers 85% to 90% have a mental health disorder at the time of the suicide while 10 to 15% die of an impulsive reaction to a

painful event. The break-up of a relationship, a sense of deep humiliation or retribution when the teen feels wronged by another all can lead to an impulsive suicide death. Talking with teens about the ambivalence of suicidal individuals may save lives. When they understand there are alternatives to ending psychological pain without ending their life, an unnecessary death may be prevented.

Talking to students is a central part of any suicide prevention effort. I learned early on that, of adolescents who kill themselves, 80% tell someone before they die. But they are most likely to tell another adolescent, usually a friend, not their parents, and not someone who is likely to take action on their behalf.

I began going into tenth grade health classes and teaching part of the unit that covers mental health, specifically adolescent depression and suicide. In addition to recognizing the signs of depression, my message to these teens is that they may be the only one who knows their friend is depressed and potentially suicidal. They may be the only person who can seek help for their despairing friend and potentially save a life. I only later learned that this strategy is known as "peer gatekeeper training."

I also began offering a mental health support group within my school. This group is specifically for students who have had a psychiatric hospitalization or a suicide attempt. We know that the people at highest risk for a suicide attempt are those who have already made an attempt. Additionally, those with a psychiatric diagnosis, particularly a mood disorder, are at high risk. Such school-based support groups function both to provide services to students in need, but also to keep a watchful eye on the well-being of this vulnerable population. Three years ago I had so many students with this need that I formed two weekly sessions of the group to meet the demand. It is a group that is on-going and not time-limited. This means that I have students who enter as freshman and remain in the group until graduation if the need continues. I should also interject that this group has included a valedictorian, a recruit to a Big-Ten football program, and many bright, talented and ultimately successful individuals. You see, depression and suicidal feelings can affect anyone, and often disproportionately impact highly intelligent and creative people.

The single largest cause of suicide is untreated or under-treated depression. I had been a volunteer screener in the community on national depression screening day for several years. When the Signs of Suicide (SOS) program became available at the high school level, I sought permission to begin depression screening at my school. We offer the screening on a voluntary basis, but require parental permission. We enlist students to make posters advertising the screening and a videotaped "commercial" that is played on the televised morning announcements in advance of the screening day. In this manner the message is from student to student, encouraging their peers to take advantage of the opportunity. In the 4 years we have been offering depression screening, well over a hundred students have been screened. One was immediately hospitalized and many have entered therapy.

A particularly poignant situation was when a mother phoned after her daughter brought home the literature and permission form. She was skeptical and indicated she and her daughter had an exceptionally close relationship and good communication. She indicated she would know if her daughter were depressed. The mother agreed when I asked what she had to lose by signing the permission. The result was an indication of some very serious issues and her mother followed through immediately by seeking treatment. Six months later she emailed me with a lovely thank you message. She reported that the family had entered treatment together and in that time had resolved issues they had not previously recognized. She praised the depression screening as the event that brought her family the opportunity to grow closer and become stronger. As in this case, many times there is not a serious depression, but instead there are stresses and life events which are creating pain for the student. In these cases the depression screening is providing an outlet for expression of that pain so that help can be gotten.

While the use of screenings and assessments are critical to this effort, they are only a first step. There must be an established system to address the needs of the students who screen positively for mental health service needs. Further, there must be prevention programs in place to catch many of the students who do not get screened. The support and infrastructure must be part of the school environment to ensure access to services and necessary follow-up.

We also need to understand and eliminate the contributing factors to suicide.

A significant factor in suicide attempts and deaths is the use of drugs and alcohol. Fifty percent of teens who die by suicide have significantly high blood alcohol levels or blood chemistry levels at the time of their deaths. Simply stated, 50% of teens are drunk or high at the time of their deaths. The dis-inhibiting effects of the alcohol or drugs may be the dynamic which tips the scale toward death rather than life. Many times when I'm interviewing students at my school because of concerns about

depression or suicide I ask if they have been thinking about suicide. The most common response I hear under those circumstances is: "Sure. Everybody does. But I wouldn't really do it." I believe those people are wrong on two counts: Not everyone considers suicide. Some people who are very depressed never consider suicide. Brain research will, no doubt, provide an answer some day why some people tend toward suicide and others never do, even under grim circumstances. But I believe that access to alcohol or drugs when an individual is feeling hopelessness and despair can lead to a fatal outcome. While they might not take action to commit suicide while sober, the substance abuse can mobilize them to take unfortunate action.

The other factor that greatly impacts the outcome in these pivotal times is access to a lethal means. Specifically access to a firearm all too often results in the permanent solution to a temporary problem. Nearly two-thirds of adolescent suicide deaths happen by firearm, just as in the adult population. Study after study in the United States and elsewhere indicate that restriction of access to lethal means saves lives. When blocked from following through on a plan, frequently the chain of events is interrupted. The person lives. On a side-note, I would like to thank you, Chairman DeWine, Senator Kennedy, Senator Reed and other members of the Subcommittee for supporting S.1807 to close the gun show loophole and, hopefully, prevent juveniles from buying firearms at gun shows.

Suicide also leaves a legacy of suicide. The immediate family and closest friends of a suicide victim are at eight times greater risk for suicide themselves. Schools can help minimize this risk.

Five years ago, the year began at my school with the suicide deaths of two students in a three-week period. These events prompted my school to ask the executive director of the American Association of Suicidology to educate us further to ensure we were doing everything possible to prevent another student death. My commitment to suicide prevention was increased further in hearing Dr. Lanny Berman speak. I offered a support group to the students who were friends of deceased. This was a powerful and productive experience-several of these students had found phone messages or email messages from their friend that left them devastated that they had not received them in time to reach out and help. For all of them the loss was excruciating and powerful. But helping these teens deal with the death and understand it as an unfortunate choice will hopefully keep them from ever making that choice. It was reassuring and rewarding to see them reach a point of being able to return to fond memories from the life of their friend instead of remaining stuck in the horror of an unnecessary death.

Teens looking forward to graduation and meeting the next phase in their lives have reflected, "I can't believe that 2 years ago my brain was telling me to kill myself." In the middle of a serious depression the individual is overwhelmed with a sense of hopelessness and the belief that it won't ever get better. But rational thinking helps us to see that usually things do get better. The depression lifts, a new friend comes along, a new opportunity emerges and hope and happiness are restored. During a serious depression, the thinking is not rational. People whose thinking is flawed by the overwhelming gloom of depression are often reliant on family and friends to get them the help they need to survive to see a better day.

Schools can play a critical role, as well.

Teens do not generally have independent access to mental health services. Increasing access to school-based mental health services is vital to our efforts to improve suicide prevention. Students need to have someone who is visible and in a familiar setting to feel comfortable in seeking help. Still, even if there are mental health professionals working in their school, many teens are unaware. One of the benefits of my peer gatekeeper training is that all of the students learn I am available to them. I see a great number of students who ask for my support and have also had good success in getting them into treatment. However, as the National Institute of Mental Health (NIMH) indicates, of some 7.5 million children under the age of 18 requiring mental health services, only one in five children receive needed services.

This statistic not only has alarming implications for suicide rates but also for other dangerous risk behaviors. We are seeing an increasing number of students engaging in intentional self-injury and substance abuse. The use of alcohol and other drugs to self-medicate mood disorders is common. I believe there is a general lack of awareness that substance abuse may not be the result of simply partying, but instead reflect self-medication of depression. It would be far simpler to treat a mood disorder than to break the cycle of substance abuse and relapse when an individual is struggling with an underlying depression. I believe that any efforts to ensure that our schools are safe and drug-free, must also include school-based mental health services to address the great need of these students. Although the No Child Left Behind Act includes mental health services as an allowable use of funds under the

Safe and Drug Free Schools Program, there is tough competition for these limited funds and such services are frequently not offered. Support for mental health programs needs to come from the top levels of federal, state and local education policy leaders.

I am hopeful that my school can help me collect data on the effectiveness of these efforts with our students. Since it is not possible to measure suicides that don't happen, my hope is that research would show that the peer gatekeeper training and exposure to advertising for depression screening affect the student's attitudes toward help-seeking. My hope is that research would indicate what I observe anecdotally: students who have been exposed to these programs are more likely to tell an adult if they are depressed or suicidal or if they are concerned about a friend. I have seen an increase in students who tell the adults at school. For example, a boy went to his guidance counselor and said he should go to John Doe's web page and see what was posted. The result is that John Doe is now in a partial hospitalization program. His parents are very grateful to know that he was planning a suicide before it occurred. In the most dramatic episode, a student called 911 and revealed a suicide plan in progress by his friend. The police department utilized heat-sensing technology in a helicopter to locate a warm spot in the woods. Police officers went in and found the boy unconscious on a winter night after he had consumed alcohol and injected himself with morphine. Our teens are finding more serious and frightening ways to act out their psychological pain.

As professionals, we are better positioned and trained to help as well. Six years ago I transported a senior in high school to an emergency mental health service after her legal guardian refused. She had let me know she was having suicidal thoughts. The psychiatrist diagnosed depression and prescribed an antidepressant medication. The community mental health clinic provided therapy based on her individual capacity to pay. This past December she graduated with a master's degree in clinical psychology-also with no financial support from her family.

The President's New Freedom Commission on Mental Health report, Achieving the Promise: Transforming Mental Health Care in America, indicates the need for schools to play a crucial role in identifying students in need of mental health treatment as well as linking them to services. The Commission specifically recommends that: Schools work with parents and local agencies to support screening, assessment, and early intervention; Mental health services become part of all school health centers; School-based mental health services be federally funded; Empirically supported approaches be used for prevention and early intervention; and State-level structures for school-based mental health services be created to provide consistent leadership and collaboration between education, general health, and mental health systems.

I am in whole-hearted agreement. Our linkages between school and community-based services need to be enhanced. The health and well-being of our next generations depend on our capacity provide effective suicide prevention education and services.

Thank you for the opportunity to address this panel. I look forward to hearing more from the Subcommittee on the issue of suicide prevention and hope you can include support for more school-based mental health and prevention programs in future legislation.

APPENDIX—EXTRACTED FROM THE GENERAL LITERATURE BY FRAN GATLIN

Principles for Talking With Teens About Suicide

- Talk about suicide should focus on the data that the vast majority of suicide deaths are completed by individuals with a diagnosable mental illness.
- The majority of individuals who die by suicide are depressed or have bipolar illness (formerly known as manic depression).
- Depression is a treatable illness.
- A suicide attempt frequently is accompanied by significant feelings of ambivalence. The person doesn't necessarily want to die; but doesn't see an alternative for ending the psychological pain he is feeling.
- A teen may be the only person who knows a friend is depressed or potentially suicidal. The majority of teens who tell someone they are contemplating suicide, tell a peer.
- Telling an adult is not "ratting" on a friend, it is help-seeking.
- Use of alcohol or illegal drugs is a dangerous dynamic, particularly when a teen is depressed. It could be the factor that mobilizes a teen to commit suicide.
- Access to lethal means, such as firearms, increases the chance of a fatal outcome. Restriction of means saves lives.

• Suicide, which is the third-leading cause of death among teens, is a preventable form of death.
• Suicide leaves a legacy of suicide. It puts the family and closest friends at eight times greater risk for suicide themselves.
• Pair any discussion about suicide with information about who to see to seek help.

Things to Avoid in Talking With Teens About Suicide

• Talking about specific means of suicide should be avoided when possible. It sometimes plants an idea.
• Avoid romanticizing the topic in any way possible. Framing it as resulting from mental illness or making an unfortunate choice is safer.
• Avoid videos, particularly those which use attractive teens who talk about surviving a previous attempt. This may plant the idea they too will survive and be a "hero" or a "legend" with their peers.

RESPONSE TO QUESTIONS OF SENATOR BINGAMAN FROM FRAN GATLIN

Question 1. Access to treatment for mental illness is a serious problem in this country. Yet there is a reluctance to cover mental illnesses at the same level as physical illnesses. How important is health insurance parity between mental and physical illnesses in reducing the risk for suicidal behavior?

Answer 1. We need to change the thinking in this country that there is a difference between the physical nature of illnesses which occur "below the neck and above the neck." Depression is no less physical an illness than diabetes. Such thinking not only limits funding for treatment but contributes to the shame and continued stigma which stop many people from seeking treatment. For a pragmatic individual, one needs only look at the costs in lost work productivity to see that it is cost-effective to not only provide early treatment but also to do prevention work. Prevention and early treatment can reduce the level of impact in which people become hopeless, despairing and suicidal.

Question 2. The New Freedom Commission on Mental Health and the Surgeon General's 1999 Report on Mental Health both identified a national shortage of mental health professionals trained to treat mental illness in children and adolescents. How can we reduce this shortage?

Answer 2. It seems that a relatively small amount of money in scholarship, stipend and internship programs could help encourage people to consider these fields. When parents lose a child to suicide they often look for ways of preventing other children from dying. This would be an excellent way for such parents to have an impact on future generations. Endowment of scholarships could help to reduce the shortfall of mental health professionals available to meet the increasing mental health needs of our children and adolescents. Additionally, publicity about the need in these (sometimes well-paying) fields may encourage young adults to consider them. Because these fields require a high level of education before the person is employed, financial aid may help more people to complete these courses of study. (School psychologists have the highest entry-level certification requirement of any school-based professional.)

Question 3. Adolescents with mood disorders, such as major depression and bipolar disorder, are at high risk for suicide. How effective are current treatments for early-onset mood disorders? How can we make evidence-based treatments available to more vulnerable young people?

Answer 3. There has been a great deal of information in the press lately about untested treatments used with children and adolescents. The result has been an increased fearfulness of parents to fill prescriptions ordered by the medical doctor or psychiatrist. Clearly we need more study of the efficacy and safety of these medications. We need funding for a state-of-the-art psychiatric diagnostic facility specifically for children and adolescents. This would stimulate understanding at the local level of best-practices treatment of a population which too frequently receive treatment as "not fully-developed adults."

The same dynamic is true of school-based suicide prevention. The literature is full of reports of the problems and dangers of such prevention programs. I am hopeful that my county will undertake research into the effectiveness of my school-based prevention efforts. In the meanwhile, I believe, that it is dangerous to do nothing. For that reason I supplied an appendix in my written testimony which extracts from the available literature the do's and don'ts of talking with groups of adolescents about suicide.

Question 4. Substance abuse is also a high-risk factor for suicide. What programs are most effective in reducing adolescent substance abuse?

Answer 4. I'm pleased to see public service announcements like "Parents: the anti-drug" on television. Teens need greater supervision than they typically receive today. They need more information about the extent to which substance abuse is related to "selfmedicating" depression and other mood disorders. Teens need support and services when they live with substance abusing parents. This is an enormous societal problem. I believe the figure is that one in four teens lives in a home where someone in the family is a substance abuser. The most direct answer to your question is that I am not aware of any program with researched effectiveness in reducing adolescent substance abuse.

Question 5. Teenage suicides are always tragic, but there is a consistently high Native American adolescent suicide rate and a recent dramatic increase in the African American suicide rate. Do you recommend intense federally supported interventions to address the risk factors that result in these statistics?

Answer 5. You are certainly right about the incidence of suicide in the Native American populations. Those groups have all the highest risk factors: high rates of substance abuse, living in rural areas, isolated from mental health support services, the presence of firearms in the home, and the reduction or loss of traditional cultural practices, values and support systems. I find it important to draw a distinction in considering African-American youth suicide rates. African-American females have extremely low rates—the lowest among our demographic groups. When I've engaged African-American women about the reason for this impressive fact they tend to cite the "sisterhood" they feel—the support they receive from their peers in coping with life's trials. African-American male youth suicide rates, however, have risen dramatically. I believe this is a population which feels very isolated from supports and are unlikely to access supports which are available. The dynamics which have resulted in more African-American males being in prison than in colleges are, I believe, having a profound effect on that population. There is a very revealing book on this issue: Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African-Americans by Alvin Poissaint and Amy Alexander. I believe that research, education, prevention, and additional services are all important to reduce the psychological pain and suicide in these populations. However I don't believe we have enough information to put into place "intense federally supported interventions" at this time.

Question 6. Schools serve as gatekeepers for the early identification and referral of young people with mental illness. How can we prepare schools to serve more effectively in this role?

Answer 6. School systems rarely have school-based school psychologists and social workers (even on a part-time basis). More frequently this staff is allocated to be at the school to do individual evaluations or specific meetings. In other districts these services are provided on a contractual basis with community mental health or private practitioners. Until there are well-trained mental health staff available on a regular basis in schools, school-based intervention can not be effective. Students need to be aware of well-trained and professional staff who are available to them on a predictable basis. Staff need to be trained to refer students with significant warning signs. Most importantly, though, students need to be trained to seek help for their peers who are at risk. Students are frequently the only people who know of other students with mental health issues or suicidal thoughts.

Question 7. Over 1,400 school-based health centers deliver primary preventive and early intervention services to more than a million children in 45 States. Mental health counseling is the leading reason for visits by students and the fastest growing component of school-based care. How can we expand the availability of such services?

Answer 7. My belief is that the numbers in your question are a grand overstatement of school-based mental health services currently in existence. That is a goal we should work toward. The lack of funding and the number of adequately trained staff to do such important work limit the true practice of effective prevention work.

Response to Questions of Senator Dodd From Fran Gatlin

In addition to screening and assessment for depression and other mental illnesses I believe there should be effective linkages to the appropriate community-based services and private mental health professionals. We have limited opportunities to link students and their families to services. If we refer them to the community mental health center and they are placed on a 4 month waiting list, there is little chance

the student will ever receive services. Our practice must be to carefully refer to available services and those which are within the economic means of the family. In today's managed care that often means we need to have the parents bring their insurance provider list and help them select practitioners who are trained in the area of the student's need. I believe it is important to provide as many school-based services as staffing-level permits. Support groups within schools can help to meet the needs of students with depression and other mood disorders, students with histories of suicide attempts, psychiatric hospitalizations, substance abuse problems and other risk factors for suicide. Schools can also provide education for staff, parents and students to reduce stigma, encourage help-seeking and encourage wellness as preventive of risk factors.

I am not aware of a model program currently. I have asked for support in researching the effectiveness of my work at my high school. We, of course, need research evidence of effectiveness before we seek to replicate programs.

Question 1. What are some of the principle mental health needs of students you evaluate in your school?

Answer 1. With 3,000 students at my school the needs are very diverse. I'm very sad to report that one of the students to whom I referred in my testimony on Tuesday died on Thursday. There are endless reminders of the extreme seriousness of the mental health needs of our youth today. I deal with many depressed high school students. Their issues are not usually so simple as to be covered with one diagnostic label. My response to your question was just interrupted to interview a student who is diagnosed with depression and who cuts herself (self-mutilation). She is in private treatment and takes an antidepressant. Because these are issues of longstanding I invited her to join the mental health support group I offer which meets weekly at school. Substance abuse, obsessive-compulsive disorder (and other anxiety disorders) and eating disorders frequently co-occur with depression. The mother of a student in my mental health group phoned this morning to say her daughter had been hospitalized yesterday evening for the second time because of her eating disorder. The services we offer at school generally do not replace but support the private, community-based treatments the students are receiving. In addition to providing a variety of support groups, and the sessions I do on adolescent depression and suicide in their health classes, students can walk in at any time to talk about their own concerns or about their friends or family. Parents call or stop in to ask for help, suggestions or referrals to treatment.

Question 2. How can we best talk with groups of students about suicide and make certain we don't unintentionally romanticize the subject?

Answer 2. I added an appendix to my written testimony in order to distill the existing literature for the best ways to talk with teens about this issue. There have been so many concerns about talking about suicide in the wrong way that many people are afraid to try. It is crucial to frame any talk about suicide within the context of mental illness. At least 85 percent of suicide occurs as the result of untreated depression or other mental illness. Teens get the message that there is nothing glamorous about mental illness, even if the person affected is a rock star. Teens also respond to the notion that the quality of thinking is distorted with a severe depression. The result of the distortion is the person's inability to see another solution to ending the psychological pain they are experiencing other than ending their life. Teens readily see that there are other solutions and that suicide is a bad decision when their thinking is healthy. Finally we must always present the idea that alcohol and drugs not only complicate effective treatment for depression and other mental health problems, but also may be the factor that pushes the individual "over the edge" to complete a suicide.

ALLIANCE FOR HUMAN RESEARCH PROTECTION (AHRP),
NEW YORK, NY 10023,
March 2, 2004.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
U.S. Senate,
Washington, D.C. 20510.

Re: Evidence linking antidepressant drugs to increased suicidal risk for children

Public concern about the safety of antidepressant drugs is intensifying as reports continue to emerge about increased suicide [1] and suicidal acts by children for whom these drugs are routinely prescribed. To obtain unbiased information and insight about this growing crisis affecting American children, one must turn to Britain. A

British Member of Parliament recently stated in Parliament that 10 million children in the United States have been prescribed antidepressants [2]—despite a lack of evidence that these drugs are of any benefit for children. UK drug regulators took action to protect British children [3] from drugs that pose an increased risk of suicide and suicidal behavior. In sharp contrast, the FDA has taken no action to protect American children.

American parents don't know what to believe, lacking clear guidance from the professionals from whom they seek help, their fears and anxiety are further increased by the persistent contradictory advice they are given by promoters of antidepressant drugs—almost all of who have financial ties to the manufacturers of these drugs. The psychiatric and general medical establishment and the FDA are waffling about acknowledging the role of antidepressants in reports of self-destructive threats and suicidal behavior. But this was made abundantly clear during the course of a hearing convened by the FDA, on February 2, 2004. An FDA advisory committee meeting addressed the growing controversy about the safety of antidepressants for children and the public health crisis. About 60 family members from all parts of the United States testified about the harrowing drug-induced suicidal behavior of their children, soon after they were prescribed an antidepressant such as Prozac, Zoloft, Paxil, Effexor. Those testimonies corroborate previously concealed evidence from company controlled clinical trials, leading the committee to urge the FDA to add warning labels without delay about the potential suicide risk that antidepressant drugs pose for a minority of children.

The Alliance for Human Research Protection (AHRP), an independent national network of concerned professional and lay people dedicated to openness and full disclosure, is taking the initiative in bringing to this committee's attention a body of evidence that may have been deliberately kept hidden from the committee. This committee will be ill advised, indeed, should it issue any recommendations without first carefully examining the disturbing but credible body of evidence about the hazards of antidepressant drugs of the selective serotonin reuptake inhibitors class.

As early as 1991, it was found that in a Prozac study, 6 of 42 children who tested Prozac became suicidal.[4] Independent, non-industry controlled analyses of the data from clinical trials and clinical experience, coupled with recently uncovered confidential company documents [5 6] reveal a consistent pattern of increased suicidal behavior in children prescribed an SSRI compared to those given a placebo. There is a body of evidence to prove that the medical community and the public have been largely misled (if not deceived) by pharmaceutical company statements, advertisements and reports.[7 8 9 10] The very integrity of the scientific literature that guides doctors' practice has been tainted by reports that rely on partial (positive) findings [11 12] written by ghostwriters [13] and psychiatrists with substantial conflicts of interest.[14 15]

Despite the evidence, the FDA has refused to take precautionary action on behalf of children. The FDA has allowed false claims about the efficacy and safety of the SSRIs to go unchecked in shaping the behavior of prescribing physicians and the public. Only after the British announced a ban on Paxil (June 2003), did the FDA announce an intention to conduct a review of all pediatric SSRI trial data. Why did the FDA fail—all these years—to conduct a scientifically valid review of the complete data set?

Not only has the FDA failed to carry out its mission of "protecting the public health" by requiring manufacturers to demonstrate the safety and efficacy of drugs according to rigorous scientific standards, but the FDA has also actually abetted drug companies to circumvent Federal regulations that require prominent warning labels to be used when there is "reasonable evidence" of an associated serious risk.[16]

More galling still are actions taken by the FDA to intervene in court cases to help drug manufacturers evade State laws that mandate truth in advertising. In August 2002, the FDA intervened with a Federal judge's order requiring GlaxoSmithKline (GSK) to stop advertising "Paxil is non-habit forming," because the commercials were "misleading and created inaccurate expectations about the ease of withdrawal." The FDA argued that it alone was authorized to determine what should be disclosed in drug advertisements.[17 18]

Two months later, on October 13, 2002, the BBC-Panorama [19] documentary provided compelling evidence of patients' extreme difficulty in withdrawing from Paxil. BBC received 67,000 phone calls and 1,500 e-mails providing additional evidence of Paxil-induced severe withdrawal symptoms. On June 18, 2003, GSK issued a letter [20] to UK healthcare professionals alerting them of changes in the Seroxat/Paxil label: changes include deletion of the claim "Seroxat/Paxil is non-addictive," acknowledgment of adverse side-effects, and advising UK doctors not to prescribe Paxil for children.

The U.S. Code of Federal Regulations, 21 C.F.R. §§ 201.57(e), requires prominent warnings whenever there is "reasonable evidence of a possible association of the drug with a serious health hazard." Although the Code does not say evidence of causation, but "reasonable evidence," Daniel Troy, FDA's Chief Counsel misrepresented the language of that Federal regulation in Amicus Curiae brief that was submitted on FDA's behalf, in 2003, in support of Pfizer Pharmaceuticals (his former client) in U.S. Court of Appeals, 9th District. (See attached) The brief claimed: that a State may not require any such warnings"—no matter the warning's language . . . any warning that suggested a causal relationship between Zoloft and suicide would have been false or misleading, and thus would have misbranded the drug." (p. 15, 17) The brief further asserts, "had Pfizer given a warning as to a causal relation between Zoloft and suicide, FDA would have disapproved that warning . . . because it would be contrary to Federal law." (p. 15) Furthermore, the Chief Counsel said, "FDA's regulation of prescription drugs is designed to ensure each drug's optimal use . . . under-utilization of a drug . . . could well frustrate the purposes of Federal regulation." (p. 23)

Was this the intent of Congress when it authorized the FDA to protect the public health, or is this an abuse of FDA authority?

Even without scientifically valid supporting evidence, senior FDA officials pronounced these drugs safe and effective in briefs submitted to judicial bodies. They made these pronouncements on the basis of cursory reviews of partial evidence and incomplete reports submitted by the manufacturers.[8] There is also evidence that senior FDA officials suppressed the agency's own medical officer's report[21] because his review corroborated the suicidal findings of the British Medicines Authority.[22] The arguments put forth by senior FDA officials are contradicted by the suicidal warnings issued to physicians in the UK by two of SSRI drug manufacturers—GlaxoSmithKline[23] and Wyeth[24] Pharmaceuticals.

Attached are seven documents to help the committee in its investigation of the issues:

(1) AHRP comments submitted to the FDA advisory committee review of the safety evidence;

(2) Correspondence between AHRP and FDA regarding implementation of FDA rule to prevent conflict of interests to taint the advisory committee process;

(3) AHRP letter to Dr. Janet Woodcock, requesting FDA's SSRI data for independent analysis;

(4) An open letter to the FDA by the foremost international expert on antidepressants, Dr. David Healy, detailing more than "reasonable evidence" of an association between SSRIs and suicidal and aggressive behavior in children and in healthy volunteers—based on a combination of raw clinical trial data files of the drug manufacturers—some not seen by FDA reviewers—and FDA medical reviews;

(5) Copy of FDA brief in Paxil litigation with declaration by Robert Temple, M.D., claiming an "in-depth" review concluded "the drug is, in fact, not habit forming;"

(6) Copy of an Amicus Curiae brief in support of Pfizer, Inc. submitted by FDA's Chief Counsel, claiming "any warning by Pfizer that suggested causation would have subjected the company to Federal regulatory enforcement action." (p. 13)

We believe that the FDA's failure to issue label warnings when there is "reasonable evidence" to inform physicians and parents about these drugs' potential hazards, as well as their failure to demonstrate a benefit for children, is exacerbating the problem and contributing to increasing numbers of preventable deaths.

Sincerely,

VERA HASSNER SHARAV,
President, Alliance for Human Research Protection.

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JOINT STATEMENT FROM THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY AND THE AMERICAN PSYCHIATRIC ASSOCIATION

INTRODUCTION

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 7,000 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7–12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP supports research, continuing medical education and access to quality care. Child and adolescent psychiatrists are the only medical specialists fully trained in the treatment of mental illness in children and adolescents.

The American Psychiatric Association (APA) is a national medical specialty society, founded in 1844, whose 38,000 members specialize in the diagnosis, treatment and prevention of mental illnesses including substance abuse disorders.

The AACAP and APA would like to thank Senator Mike DeWine (R–OH), chairman of the Substance Abuse and Mental Health Services Subcommittee for holding this hearing and for his continued commitment to improving access to treatment for mental illnesses for children and adolescents.

Suicidal behavior is a matter of grave concern for child and adolescent psychiatrists who treat children and adolescents. Suicide, very rare before puberty, becomes increasingly frequent through adolescence. The incidence of suicide attempts reaches a peak during the mid-adolescent years, and mortality from suicide, which increases steadily through the teen years, is the third leading cause of death for teenagers. According to the *Surgeon General's Call to Action to Prevent Suicide*, 1999, from 1980–1996, the rate of suicide among persons aged 15–19 years increased by 14 percent and among persons aged 10–14 years by 100 percent.

The factors that predispose to completed suicide are many and include pre-existing psychiatric disorders and both biological and social-psychological facilitating factors. The overwhelming majority of adolescents who commit suicide (more than 90 percent) suffered from an associated psychiatric disorder at the time of their death. The top risk factors for attempted suicide in adolescents are depression, alcohol or other drug use disorder, and aggressive or disruptive behavior.

Even the most experienced physician can find it difficult to differentiate between benign and ominous suicidal behavior; although, depressive disorder can predict an immediate risk. Many adolescents who have made a medically serious attempt will never do so again, while others who have made what seemed like only a mild "gesture" may eventually commit suicide. The impact of such a "gesture," called so by some clinicians to denote a nonlethal action that is deemed a cry for help, is therefore misleading because it minimizes the potential risk for suicidal behavior. Unfortunately, one cannot gauge future suicidal behavior. Despite this fact, research has provided some broad indicators about risk factors that should be considered by all physicians dealing with patients exhibiting suicidal behaviors. In general, males are at a much higher risk for suicide than females. The high risk factors for suicide among males include:

- Previous suicide attempt
- Aged 16 years or older
- Associated mood disorder
- Associated substance abuse

The high risk factors among females include:

- Mood disorders
- Previous suicide attempts

Some of the psychiatric illnesses in adolescents which include suicidal thoughts or behaviors include depression, ADHD, and bipolar disorder. Of these, depression

has been identified as the top risk factor. About 5 percent of children and adolescents in the general population are depressed at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. The behavior of depressed teenagers may differ from the behavior of depressed adults. For example, depressed teenage boys often exhibit aggressive or risk-taking behavior.

Teenagers with bipolar disorder may have an ongoing combination of extremely high (manic) and low (depressed) moods. Although less common, it does occur in teenagers. Family history of drug or alcohol abuse also may be associated with bipolar disorder in teens. Bipolar disorder may begin either with manic or depressive symptoms. Its manic symptoms include severe changes in mood, including irritability, a significant increase in energy and the ability to go with little sleep, distractability, and repeated risk-taking behavior, such as abusing alcohol or drugs, or reckless driving. Depressive symptoms include persistent sadness, thoughts of death or suicide and a low energy level.

Minority and Gay Adolescents

According to the Surgeon General, from 1980 to 1996, the suicide rate for African American males aged 15–19 has increased 105 percent. Some research has pointed to increased access to firearms in African American communities. The only consistent research findings, however, point to very similar risk factors for young African Americans as those for white youth, including long-term depression and substance abuse. More research is needed to determine what, if any other risk factors are attributable to the rise in African American youth suicide.

There is strong evidence that gay, lesbian and bisexual youth of both sexes are significantly more likely to experience suicidal thoughts and attempted suicide. A number of studies have shown that the increased risk ranges from 2-fold to 7-fold. Gay, lesbian and bisexual youths were shown in these studies to carry a number of risk factors for suicidal behavior, including high rates of drug and alcohol use. Gay adolescents are at significant risk for suicide due to chronic bullying and victimization at school.

Prevention

Public health approaches to suicide prevention have targeted suicidal children or adolescents, the adults who interact with them, their friends, pediatricians and the media. One initiative is telephone hotlines. Although widely used, preliminary research has shown that hotlines do not reduce the incidence of suicide. More study is needed to determine their overall effectiveness. Some studies have shown that restricting young people's access to firearms may result in a short-term reduction in the rates of suicide, but there is not yet evidence that this has a permanent effect.

Traditional suicide prevention programs used frequently minimize the role of mental illness, and, although designed to encourage self-disclosure by students or third party disclosure by friends, these initiatives have not been shown to be effective against suicidal behavior. A safer approach might be to focus on the clinical signs of depression or other mental illnesses that predispose to suicidality. Screening or suicide prevention programs should include procedures to evaluate and refer teenagers at serious risk for suicide. It is advisable for teachers and counselors to use questionnaires to screen for depression and suicidal behavior. Those identified as being at risk should be referred to a child and adolescent psychiatrist for further evaluation and treatment.

Treatment

Successful treatment depends on a number of factors, with safety considerations being of the utmost importance. The good news is that treatment options for mental illnesses, including the disorders that lead to suicidal behaviors, are increasing.

Because of the need to respond to a suicide crisis, treatment should ideally be provided within a "wrap around" service delivery system that includes resources for inpatient, short and long-term outpatient, and emergency intervention. Adolescents who have attempted suicide should be hospitalized if their condition makes behavior unpredictable. Outpatient treatment should be used when the adolescent is not likely to act on suicidal impulses, when there is adequate support at home, and when there is someone who can take action if the adolescent's behavior or mood deteriorates. The prescribing of antidepressants to depressed individuals, combined with therapy, has been found to be effective in reducing suicides, particularly among children and adolescents.

Policy Recommendations

The AACAP supports the following policies that relate to teen suicide prevention and treatment:

• The creation and funding of suicide prevention programs which destigmatize mental illness and include screening instruments to identify adolescents at risk for suicide.
• Increased access to mental health care will prevent adolescent suicide. Barriers to accessing appropriate mental health care, including cost and availability of specialists, such as child and adolescents psychiatrists, must be removed. Enactment of State and Federal mental health parity laws will remove the cost barrier for children, adolescents and their families.
• The implementation of community-based early intervention strategies which identify children and adolescents with emotional and behavioral. Adolescents who display signs and symptoms of these problems should be referred for evaluation and treatment by a mental health professional who has specific training, experience and expertise in working with children and adolescents.
• School-based mental health programs are the first line of defense for identifying children and adolescents with emotional or behavioral problems. Receiving services in a school-based health center is easier than going to a private office or a community clinic for many adolescents, especially those from lower-income backgrounds.
• Expanded geographic and financial access to drug and alcohol treatment will help prevent adolescent suicide, since drug and alcohol abuse presents a high risk factor for suicide.
• Increasing research into the causes of suicide and effective treatments.
• Increasing training support for mental health specialists like child and adolescent psychiatrists.
• Reform of the juvenile justice system with the inclusion of comprehensive mental health services for youth offenders including screening, evaluation and wrap-around treatment.
• Reform of the foster care system so that children receive comprehensive mental health services including screening, evaluation and wrap-around treatment.
• The creation of comprehensive community-based systems of care including access to psychiatric hospitalization.
• Increased State and Federal support for child abuse prevention. Abused children are at high risk for developing long-term depression and other mental illness as a result of abuse.
• Increased State, local and Federal support for adolescent pregnancy prevention.
• Increased local, State and Federal support for bullying prevention programs in schools and communities. Recent studies have revealed that children and adolescents who are bullied are at high risk for suicide.

The AACAP and APA appreciate this opportunity to submit a statement for the record for this important hearing. Please contact Nuala S. Moore, AACAP Assistant Director of Government Affairs, for more information about teen suicide at 202.966.7300, ext. 126.

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PREPARED STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association (AOTA) submits this statement for the record of the March 2, 2004 hearing. We appreciate the opportunity to provide this information regarding the relationship of occupational therapy services to meeting the needs of children and youth with mental health needs and who are at risk for suicide. It is critical for Congress to be aware of issues regarding America's public health needs so that it can develop appropriate national policies to meet society's needs. The topic of this hearing is critical to the development of a better, clearer picture of how to address the growing problem of youth suicide.

Issues related to mental health needs in this country have been clearly articulated in numerous sources, including the 1999 Surgeon General's report on mental health and the 2003 report of the President's New Freedom Commission on Mental Health. These include problems in the service delivery system, shortages of service providers, negative public attitudes about mental illness, and barriers to early identification, screening, and access to services and appropriate treatment. Data from the

Centers for Disease Control and Prevention (2000) indicates that suicide is the third leading cause of death among youth, 10–24 years of age. Furthermore, the Substance Abuse and Mental Health Services Administration (SAMSHA) reports that 36 percent of youth who are at risk for suicide (out of nearly 3 million) receive any mental health treatment. Many of these mental services are provided in schools. This fact speaks to the need for schools to effectively utilize and train all school personnel to appropriately recognize and address children's mental health needs. Occupational therapy services can play an important role in this effort.

How Occupational Therapy Helps Address Children's Mental Health Needs

Occupational therapy is concerned about an individual's ability to perform everyday activities, or *occupations*, so that they can participate in school, at home, at work, and in the community. Occupational therapists and occupational therapy assistants provide critical services to and for children and youth in a variety of educational and community settings, who have a variety of educational, learning and behavioral needs, including children that may be at risk for suicide. Occupational therapy practitioners use purposeful activities to help children and youth bridge the gap between their capacity to learn and full, successful participation in education, work, play, and leisure activities.

Occupational therapists look at the individual's strengths and needs with respect to daily life performance in school, home and community life, focusing on the relationship between the client and their performance abilities, the demands of the activity, and the physical and social contexts within which the activity is performed. In addition, each individual's occupational performance is viewed through a psychological-social-emotional lens. This perspective helps the occupational therapist to understand what is important and meaningful to the child as well as how their past roles, experiences, strengths and patterns of coping work together to shed light on current issues and problems.

Occupational therapy intervention for children and youth emphasizes functional and readiness skills and behaviors, and includes consultation with parents and families, teachers and other professionals. Services are directed toward achieving desired outcomes that were developed in collaboration with the family and other professionals.

In education-settings, occupational therapists identify the underlying performance skills, including motor, process, communication and interaction skills that impede the student's ability to participate in learning and other school-related activities. Intervention strategies and service models are designed to support desired educational outcomes, and may be provided individually or in small groups. The therapist also works with classroom teachers and the student's family to determine how to modify the home or classroom settings, routines and schedules to provide structured learning opportunities and experiences to support the student's emerging skills.

Why Occupational Therapy?

Children and youth are being challenged by many societal factors and increasingly higher standards of educational performance and achievement. They may feel pressure from parents, peers, and others to behave in certain ways or to conform to certain expectations that may be in conflict with one another. Occupational therapy intervention for these students can emphasize new skills, behaviors and more effective ways to cope with these challenges. With its roots in mental health, occupational therapy practitioners can recognize a child's social and emotional skills and assess how well they match the demands of the environment.

Occupational therapy for children/youth at risk for suicide utilizes activity-based interventions that serve as the vehicle for enhanced self-understanding, provide a reality-based structure, and supports skill acquisition or enhancement. Services focus on mobilizing both internal and external resources that support the individual's self-understanding within the context of a safe, caring relationship. Intervention strategies address interpersonal communication and other social behaviors. Strategies include helping the child learn to manage and organize their behavior and classroom work space and environment, and to complete assigned tasks. Intervention may also address underlying sensory-motor concerns that affect the student's active participation in school activities.

AOTA believes that occupational therapy is an underutilized service that can meet and address the mental health needs of children and youth in schools and the community. Services for school-aged children are intended to help them succeed in school. Intervention strategies may focus on improving the child's information-processing ability, academic skill development, and ability to function in the school environment. For adolescents, occupational therapy focuses on preparation for work life

choices, improvement of social and work skills, and learning how to create or adapt the environment to maximize productivity.

AOTA believes that many children and youth who could benefit from occupational therapy do not receive services, particularly those with mental health needs. This limited access affects both students receiving special education under the Individuals with Disabilities Education Act (IDEA) as well as students in general education. Often this limitation is due to a lack of understanding about how occupational therapy can help or because of perceptions that therapists only address "motor" issues. Occupational therapy training is comprehensive and covers physical, psychological, social and pedagogical aspects of human occupation. Occupational therapy's understanding of human performance, or "do-ing," can be invaluable in helping parents and school staff to understand the relationship between the physical and psychosocial and how these factors support or impede children's progress.

What is Occupational Therapy?

Occupational therapy is a vital health care service, designed to help individuals participate in important every day activities, or *occupations*. Occupational therapy services address underlying performance skills, including motor, process, communication and interaction skills to assist in the correction and prevention of conditions that limit an individual from fully participating in life. For children with disabling conditions and other educational needs, occupational therapy can help them to develop needed skills within the context of important learning experiences and to perform necessary daily activities such as feeding or dressing themselves and help them get along with their peers at school. Occupational therapy services can help identify strategies for teachers and families to use to facilitate appropriate reading and writing development.

Occupational therapy practitioners have the unique training to assist individuals to engage in daily life activities throughout the lifespan and across home, school, work and play environments. Services may be provided during only one period of the child's life or at several different points when the child is having difficulties engaging in his or her daily school occupations, such as when they are faced with more complex demands in the classroom resulting from increased emphasis and reliance on written output. Occupational therapy services may be provided in the family's home; at school; and in the community, such as daycare and preschool programs, private clinics, and vocational programs.

Occupational therapy evaluation determines whether an individual would benefit from intervention. The evaluation looks at the individual's strengths and needs with respect to daily life function in school, home and community life, focusing on the relationship between the client and their performance abilities, the demands of the activity, and the physical and social contexts within which the activity is performed. The findings of the occupational therapy evaluation inform the team of the need for intervention. Occupational therapy practitioners use purposeful activities to help individuals bridge the gap between capacity to learn and full and successful engagement in work, play, and leisure activities.

For example, occupational therapy for infants and young children may include remediation of problem areas, development of compensatory strategies, enhancement of strengths, and creation of environments that provide opportunities for developmentally appropriate play and learning experiences. Services for the school-aged child are intended to help them be successful in school. Intervention strategies may focus on improving the child's information-processing ability, academic skill development such as handwriting, and ability to function in the school environment. For adolescents, the occupational therapy intervention focus is on preparation for occupational choice, improving social and work skills, and learning how to create or alter the environment to maximize their productivity.

Occupational therapy is a health and rehabilitation service covered by private health insurance, Medicare, Medicaid, workers' compensation, vocational programs, behavioral health programs, early intervention programs, and education programs. AOTA represents 30,000 occupational therapists, occupational therapy assistants, and students. We thank you, once again, for the opportunity to submit our comments for the record.

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS,
BETHESDA, MD 20814,
February 23, 2004.

Hon. MIKE DEWINE,
Chairman,
Subcommittee on Substance Abuse and Mental Health Services,
Washington, DC 20510.

Hon. EDWARD M. KENNEDY,
Ranking Member,
Subcommittee on Substance Abuse and Mental Health Services,
Washington, DC 20510.

DEAR SENATORS DEWINE AND KENNEDY: I am writing to you as the Executive Director of the *National Association of School Psychologists* to express my support for the **SOS High School Suicide Prevention Program**.

Schools are an ideal place to reach and teach all students about depression and suicide. We have access to students for an extended time period. We can guide and reinforce their understanding. We can respond to their questions and we can observe and respond to their needs. My members appreciate that the SOS Program is flexible—schools can design a program as large, or small, as their needs and resources dictate. Many schools are incorporating it into their health curriculum.

The SOS Program teaches teens the signs of suicide—such as the words, behaviors, and signals—so that they will recognize them in their friends or within themselves. The program outlines action steps for dealing with those signs as a *Mental Health Emergency*, which is the unique difference in this program. Teaching teens to recognize *and appropriately respond* to the signs of potential suicidality as a mental health emergency bridges crucial awareness with action. This is a critical point.

The program helps teens to understand the important connection between suicide and undiagnosed, untreated mental illness—which typically involves depression. It teaches that suicide is not a healthy or effective way to react to stress or emotional upset. It strives to increase help-seeking behaviors in teens by teaching them to **ACT**. We chose the acronym, ACT, to reinforce the programs message of empowerment. The **A** in ACT teaches students to **acknowledge** that their friend has a serious problem; the **C** encourages students to let their friend know that they **care** about them, and, most importantly, the **T** reminds them to **tell** a trusted adult.

Recent history has shown us that, all too often, a student who is depressed and thinking of taking his own life—or someone else's life—will tell a peer beforehand, and many times more than one person. The SOS Program teaches students the difference between loyalty to their friends and keeping a secret that can kill.

The SOS Programs advisory board developed a kit of materials. It includes information for students and their parents, a Procedure Manual for professionals implementing the program, and a video. Titled, *Friends For Life: Preventing Teen Suicide*, this video is the main teaching tool of the program and dramatizes the right *and wrong* ways for students to help their friends.

The program was first introduced in the year 2000; by the second year it was in more than 1,000 schools nationwide. The SOS Program has an excellent safety profile. Participating schools report a nearly 150 percent increase in help-seeking among students who took part in the program, and approximately 90 percent of site coordinators—usually a school psychologist, nurse or counselor—agreed that the program brought students in need to their attention. The new study being published in the American Journal of Public Health that shows that the SOS program reduced suicidal attempts by 40 percent is further evidence of the importance of this program.

The National Association of School Psychologists' 22,000 members need and want programs that are easily replicable in a variety of school settings using existing staff. I believe that the SOS High School Suicide Prevention Program is one such example and that it should be fully funded and available to any high school in America who wants it. Thank you for your consideration and for all you do to support children and youth across the USA.

Sincerely,

SUSAN GORIN, CAE,
Executive Director.

PREPARED STATEMENT OF SUZANNE VOGEL-SCIBILIA, M.D.

Chairman DeWine, Senator Kennedy and Members of the Subcommittee, NAMI would first like to thank you for your leadership in holding this critically important hearing on *Suicide Prevention and Youth: Saving Lives*.

I am Suzanne Vogel-Scibilia, M.D. of Beaver, Pennsylvania, a member of the National Alliance for the Mentally Ill (NAMI) Board of Directors and a psychiatrist serving both youth and adults in my practice. In addition to serving on the NAMI Board, I am also the mother of five children. Two of my children are diagnosed with mental illnesses and one of my sons has attempted suicide—so I know first hand about this troubling issue, as do many other NAMI families.

I am pleased today to submit the following testimony on behalf of NAMI on the critically important issue of youth suicide and steps that must be taken to ensure early intervention and suicide prevention to reduce the tragically high number of youth suicides in our Nation.

NAMI is a nonprofit, grassroots support and advocacy organization of consumers, families (including parents and caregivers of children and adolescents with mental illnesses) and friends of people with serious mental illnesses. Founded in 1979, NAMI today works to achieve equitable services and treatment for more than 15 million Americans living with mental illnesses and their families.

The Crisis in Youth Suicide and Untreated Mental Illnesses

Youth suicide is a public health crisis linked to underlying mental health concerns. According to the Surgeon General's 1999 seminal report on mental health, 1 in 10 youth in the United States suffers from a mental illness severe enough to cause impairment. Yet, fewer than 1 in 5 of these young people receives needed mental health treatment.

Too many youth in our Nation with mental health needs are not receiving any services. The circumstances are worse for African-American, Native-American, Latino and other youth from ethnically and culturally diverse communities—who often bear a greater burden from unmet mental health needs (Surgeon General 2001 Report on Mental Health: Culture, Race, and Ethnicity).

We know the staggering long-term consequences for the roughly 80 percent of youth with mental illnesses who fail to receive services. Suicide is the third leading cause of death in youth aged 10 to 24. (Centers for Disease Control, 1999) Over 4,000 young lives are lost each year to suicide. Studies show that 90 percent of youth who commit suicide were suffering from a diagnosable and treatable mental illness at the time of their death (Shaffer, 1996).

It is difficult to imagine the pain associated with losing a child to suicide. NAMI wishes to acknowledge the incredible courage that Senator Gordon Smith (R–OR) and his wife exhibited at the hearing by sharing their recent and unthinkable personal loss of their young son to suicide. Their willingness to speak about this tragedy—undoubtedly one of life's most painful experiences—and his struggle with mental illness helps to raise a much broader awareness about these issues.

NAMI also appreciates the tremendous work of the Suicide Prevention Action Network (SPAN) in raising awareness and educating the public and policymakers about suicide and the impact that it has on families and communities.

Suicide is not the only disastrous consequence of untreated mental illnesses in youth. They also tragically end up in the criminal justice system. According to a recent study—the largest ever undertaken—an alarming 65 percent of boys and 75 percent of girls in juvenile detention have at least one psychiatric diagnosis. (Teplin, Archives of General Psychiatry, Vol. 59, December 2002). The prevalence rates of children and adolescents with mental illnesses in the juvenile justice system is a moral outrage and speaks to our Nation's failure to build an effective mental health treatment system.

Youth with mental illnesses also have the poorest academic achievement and the highest failure and dropout rates of any disability group. We must respond to these crises with the necessary political will to change the broken mental health system in this country.

What is the impact of untreated and poorly treated mental illnesses in children on families? Simply put—devastating. Stigma and shame drive many families away from the treatment system. Suicide severely impacts the families left behind—who often wrongly live with extreme shame and guilt over not having prevented the death of their loved one.

More children and young adults die from suicide each year than from cancer, AIDS, heart disease, chronic lung disease, stroke, and birth defects combined. Our Nation is experiencing a public health crisis related to mental illnesses in youth and

suicide. The sad reality is that we know how to treat most mental illnesses in youth and many of these tragedies could be avoided.

What Can Be Done?

Our Nation simply must make early identification of mental health needs in youth and appropriate intervention—a national priority. The need to do so is now well documented in report after report.

Schools and primary care settings are a natural place to conduct early mental health screenings and to ensure appropriate interventions for children and adolescents and their families. These settings are familiar, comfortable and low-stigma places to reach children with mental health needs and their families.

NAMI applauds the work of Laurie Flynn, the national director of the Columbia University TeenScreen program and the long-time former Executive Director of NAMI. Her testimony outlined the vital need for mental health screening for youth and the need to refer young people, when indicated, for a more thorough mental health evaluation and services. The Columbia University TeenScreen program, recognized in President Bush's New Freedom Commission on Mental Health Report, represents an effective program to detect mental health concerns in youth and to link them to appropriate services.

We also need to educate and train our Nation's school professionals about the early warning signs of mental illnesses. Families express grave concern that school professionals often do not understand even the basic facts about early onset mental illnesses. Consequently, they are not in a position to recognize the early warning signs of these disorders and to refer a student for an appropriate evaluation. Also, NAMI families report that school officials continue to blame parents for a child's mental illness—which often drives youth and families away from the treatment system.

It is also critically important that we identify youth with mental health needs and intervene with appropriate services in other child-serving systems, including—juvenile justice, substance abuse programs, the child welfare system and others. Unfortunately, most families express grave concern that these systems fail to communicate and fail to coordinate services. The children's mental health system and other child-serving systems are fragmented and overly bureaucratic. Most States and communities fail to offer home- and community-based mental health services. Families in crisis are left on their own to navigate multiple, complex systems that do not work well. This often results in youth falling through the cracks. It is vital that States and child-serving systems develop effective interagency collaboration to help identify youth at risk for suicide and in need of mental health services and offer home- and community-based mental health services.

NAMI is frequently contacted by families from across the country that have struggled to get treatment for their child's mental illness. Often these families have long since exhausted their private insurance benefits for mental health coverage (90 percent of private health insurance plans place restrictive and discriminatory caps on mental health benefits) and paying for intensive services is simply not financially feasible. Most of these families do not qualify for Medicaid benefits. State agencies and others tell many families that the only way to access critically needed treatment is by relinquishing custody of their child to the State. This causes unthinkable stress for children and families, hit at their most vulnerable moment.

One of the key barriers to treatment is the severe shortage of available specialists trained in the identification, diagnosis and treatment of childhood mental illnesses. Primary care providers report seeing a large number of children and youth with mental health problems, but have difficulty finding available clinicians to take referrals. The Surgeon General's 1999 report found that "there is a dearth of child psychiatrists, appropriately trained clinical child psychologists, or social workers." Our Nation currently has approximately 6,300 child and adolescent psychiatrists with a need of 32,000 to treat young people with mental disorders. Families are put on long waiting lists for mental health services. We must address this critical shortage of qualified children's mental health providers.

Stigma drives youth and families away from the mental health treatment system. Families are suffering a great and unnecessary burden because of the lack of effective treatment for youth with mental illnesses. The broken mental health system all too often leads to tragic consequences—including youth suicide.

Immediate Federal Action is Needed to Help Reduce Youth Suicide

NAMI applauds Senator DeWine and Senator Dodd for introducing Federal legislation—*The Youth Suicide Early Intervention and Prevention Expansion Act of 2004*—to help address the youth suicide crisis in our Nation.

This legislation provides States, local governments and other eligible entities with funding to develop and implement effective statewide youth suicide early intervention and prevention strategies. This legislation holds real promise in helping to reduce youth suicide.

Clearly, though, other steps must be taken to address the youth suicide crisis and the unacceptably high percentage of youth with untreated mental illnesses. In addition to support for the *Youth Suicide Early Intervention and Prevention Expansion Act of 2004*—NAMI asks for Congressional support of the following Federal legislation pending in Congress that can make a difference in reducing youth suicides in our Nation—

- The Paul Wellstone Mental Health Equitable Treatment Act of 2003 (S. 486 and H.R. 953)—parity legislation to end insurance discrimination in health insurance against children and adults with mental illnesses so that families can access appropriate mental health services for their loved ones (NAMI applauds Senators DeWine, Kennedy, Bingaman and Reed for cosponsoring this legislation);
- The Keeping Families Together Act (S. 1704/H.R. 3243)—provides grants to States to develop home- and community-based mental health services to serve youth with mental illnesses and their families in the least restrictive and most appropriate setting and requiring child-serving agencies to collaborate in developing an appropriate service system (NAMI applauds Senator Bingaman for cosponsoring this legislation);
- The Family Opportunity Act of 2003 (S. 622)—allows States the option of expanding Medicaid coverage to low and middle-income families on a sliding cost-sharing basis for those families that have children with the most intensive mental health service needs (NAMI applauds Senators Enzi, Ensign, Kennedy, Bingaman and Reed for cosponsoring this legislation);
- The Child Healthcare Crisis Relief Act (S. 1223 and H.R. 1359)—to address the national shortage of children's mental health specialists which acts as a barrier to families accessing timely and appropriate services for their child (NAMI applauds Senator Bingaman as the sponsor of this legislation and Senator Kennedy for cosponsoring the bill).

Conclusion

Chairman DeWine and Senator Kennedy, thank you for the opportunity to share NAMI's views on this important issue. We look forward to working with you and all members of the HELP Committee to ensure that the Senate acts on the Youth Suicide Early Intervention and Prevention Expansion Act of 2004 to reduce youth suicide in this country.

UNIVERSITY OF CONNECTICUT HEALTH CENTER,
FARMINGTON, CONNECTICUT 06030,
February 23, 2004.

Hon. MIKE DEWINE,
Chairman,
Subcommittee on Substance Abuse and Mental Health Services,
Washington, DC 20510.

Hon. EDWARD M. KENNEDY,
Ranking Member,
Subcommittee on Substance Abuse and Mental Health Services,
Washington, DC 20510.

DEAR MR. CHAIRMAN AND RANKING MEMBER: It is my pleasure to share with you the result of an Outcome Evaluation of the SOS Suicide Prevention Program.

The objective of this study was to examine the effectiveness of the SOS prevention program in reducing suicidal behavior.

We conducted the study with 2100 students in five high schools in Columbus, Georgia and Hartford, CT. The students were randomly assigned to intervention and control groups.

The results were as follows:

- Significantly lower rates of suicide attempts among those exposed to the program—a 40 percent reduction
- Greater knowledge and more adaptive attitudes about depression and suicide

We concluded that the SOS program is the **first school-based suicide prevention program to demonstrate a significant reduction in self-reported suicide attempts in a study utilizing a randomized experimental design**.

I hope this helps in your efforts to examine the important subject of teen suicide. I am available to discuss this study in more detail at anytime. I can be reached at (860) 679–3262.

Sincerely,

ROBERT H. ASELTINE, JR., PH.D.,
Associate Professor,
Department of Behavioral Sciences and Community Health,
University of Connecticut Health Center.

[Whereupon, at 11:48 a.m., the subcommittee was adjourned.]

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